VOL. 11, NO. 1 MAY-JUNE, 1961

Inventory

A BIMONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

TENTH ANNIVERSARY ISSUE

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
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INVENTORY

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RALEIGH, N. C.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

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Linking the Past . . .

INVENTORY

VOL. 1 NO. 1
MAY, 1951
RALEIGH N. C.

The purpose, aims, and hopes of Inventory as outlined in its first editorial remain apropos.

INVENTORY - A NECESSITY

IF we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

Honest inventory should produce an educational approach with four aims: to give scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, to teach personal responsibility in all alcohol matters.

A recognized step in arresting alcoholism is the personal inventory a problem drinker finally takes of himself, led by his physician, often by Alcoholics Anonymous or a minister, occasionally by his family or a close friend. The drama of excuses is at first a painful ordeal, until the fog of alcoholism gives way to the truth.

That's what it takes, according to those who know, a fearless inventory down to the roots of the sufferer's personality—psychological, physiological, sociological, spiritual probing—a human, sympathetic but firm inventory of all faults and virtues.

Perhaps society would do well to take an inventory of its own collective personality, analyzing its traditional attitudes plus or versus its current action. In contrast to the 5% considered curable only yesteryear, today's pioneer alcoholic clinics report 60 to 80% arrested cases.

This journal will present latest alcohol facts compiled by the Yale Laboratory of Applied Physiology, international authority on alcohol problems. It will feature developments in North Carolina's program, news and views of interested state-wide groups, and pertinent rehabilitation items over the nation.

Through INVENTORY, we hope every interested person will find adequate materials for taking stock of what he knows and doesn't know about this health problem.

THE EDITOR (Santford Martin, Jr.)

A broadened base of sophisticated readers is Inventory's greatest asset and hope of the future.

INVENTORY

VOL. 11 NO. 1
MAY-JUNE, 1961
RALEIGH N. C.

. . . with the Present

INVENTORY - A NECESSITY

THE purpose, aims, and hopes of INVENTORY as set forth in its first editorial remain apropos and will continue to chart the course of future issues.

Today, as ten years ago, alcoholism is an affliction of an impressive number of our citizens. There are an estimated 52,000 alcoholics in North Carolina, and the illness of each alcoholic directly affects the lives of four or five other people. Alcoholism is also a factor to be reckoned with in serious social problems which beset individuals, families and society.

Yes, the need for INVENTORY in 1961 is just as great as it was in 1951. Its purpose remains the same. Its educational aims are constant and continuous. If there is any difference in the hopes for INVENTORY, it will be found in the climate generated by its readers.

The first INVENTORY filled a vacuum. To many of its 5,000 readers, the idea of alcoholism as an illness was brand new and hard to digest. Fifty-nine issues later, INVENTORY has a readership of 18,965 people— many of whom are sophisticated readers. They scan the pages of INVENTORY not out of curiosity nor solely for information. They are looking for help in acting out in their lives the conviction that alcoholism is an illness, that the alcoholic can be helped, that he can recover.

This kind of reader will make a difference in the hopes for INVENTORY as it enters its second decade as an educational tool of the NCARP. For the reader who applies his knowledge and conviction in daily living is a person who influences other people. His example is contagious. Others are attracted by the idea he radiates and thereby encouraged to investigate. Investigation begets knowledge. Knowledge applied begets action. Action repeated begets results. Results solidify conviction, and the cycle repeats.

This contagious chain reaction enacted among a broadened base of readers is INVENTORY'S greatest asset and hope of the future.

The EDITOR (Lillian Wilson)

THE CLICHES OF ALCOHOLISM

BY HERMAN E. KRIMMEL
DIRECTOR OF CASEWORK SERVICES
CLEVELAND CENTER ON ALCOHOLISM

Alcoholics often deny their illness on the basis of isolated symptoms.

WE have tried to be reasonably diligent and persistent in our efforts to alert professional colleagues and the public to the symptoms that indicate the onset of problem drinking or alcoholism. This is important because prevention depends on early detection. Our experience during the past few years, however, has taught us the need for flexibility and clarity. Alcoholics are masters of distortion and they are incredibly adept at isolating single factors to "prove" to themselves and others that they are not really alcoholics.

Industrial management, for example, is becoming increasingly aware that absenteeism, especially on Friday, Mondays or around pay days, is sometimes an indication that an employee is a problem drinker. That awareness is good. However, the relationship between alcoholism and absenteeism has been so vigorously emphasized that some alcoholics try to deny their illness on the premise that they never miss a day from work.

A highly placed executive in a large corporation provides a good illustration. He starts to drink as soon as he leaves the office and continues until he manages to find his way home a few hours later. His behavior at the dinner table is frequently swinish. He spills more food than he eats. He denounces his wife as an unbearable scold and sees his children as impediments to his self-indulgence. When he finally lurches from the table, he continues drinking until he decides to crawl upstairs (sometimes on all fours) where he flops into bed. Obviously, his drinking has contributed to the destruction of his family life and there is some evidence that it is affecting his health. Nevertheless, he is one of those astonishing human beings who is able to reach his office on time each morning and he argues that this is conclusive evidence that he is not an alcoholic.

Unfortunately, many of these people persuade their families that as long as they work regularly and supply the daily bread that alcohol cannot be a problem. It is not unusual for a wife to call our office and ask in a puzzled tone if it is possible that her husband might be an alcoholic. After all, she points out, he has been on the same job for twenty years and seems to be regarded favorably by co-workers and


J.B.
"ME, A PROBLEM DRINKER? I NEVER MISS A DAYS WORK!"
"THOSE GUYS IN AA SURE HAVE THEIR TROUBLES!"
"THAT POOR BUM IN THE GUTTER OUGHT'A DO SOMETHING ABOUT HIS DRINKING!"
"I'M NO ALCOHOLIC, I NEVER TAKE A DRINK IN THE MORNING!"
"....ALCOHOLIC!"

superiors. We have to explain that many alcoholics do encounter employment difficulties but this does not apply to all. In other words, few alcoholics display *all* the symptoms of their illness and they cannot be permitted to use those they have avoided to provide an escape.

Another symptom that has been misused as well as used is the need for a morning drink. Certainly it is true that if a person is unable to begin his day without alcoholic fortification, he has reached a point where objective examination of his drinking pattern is indicated. Father Ralph Pfau recalls in his interesting autobiography, *Prodigal Shepherd,* that he was frightened by his insistent need for a morning drink and, as much as anything, this jolted him to an awareness of his problem. Some alcoholics, however, use their ability to resist the bottle in the morning as indisputable proof that their drinking is still well controlled. These are people who may set a time before which they will not drink. It may even be late afternoon. Their eyes are glued to the clock during the agonizing wait for the slow moving hands to the appointed hour. Then they are off and drinking to oblivion. But they are able to convince themselves that they are not alcoholics because they still exert their tortured control.

The concept of "hitting bottom" is employed by many alcoholics to avoid recognition of their illness. If they erroneously believe that "bottom" necessarily means Skid Row or the county jail or a brawl in a littered alley, they can glibly point out that they have avoided this ignominy.

We have talked with patients, for example, who failed to use the program of Alcoholics Anonymous because of this unrealistic denial. They may have listened to a lead speaker recount hair-raising and varied adventures of his drinking days. Our man, however, may have simply guzzled himself into a stupor at home and staggered into bed. He decided that since his experiences did not match the experiences of the speaker he could not be an alcoholic. Twisted thinking? Of course, but that is common among alcoholics.

All these symptoms and others are significant and must be watched closely. They should not, however, be used simply as cliches so that the alcoholic interprets the absence of one or more of them to deny his illness. Those engaged in treatment have a responsibility to remember that it is always important to help the patient face reality. As Doctors Thomas C. Murphy and Robert A. Moore told the 1960 meeting of the American Psychiatric Association, the alcoholic who has faced the facts has his battle largely won, whatever treatment he gets.

Word of Caution

One other word of caution is necessary. It is equally perilous to jump to conclusions about the presence of alcoholism on the basis of isolated symptoms. This writer was speaking to a class of high school students and confidently enumerating the various personality changes that can indicate trouble. In quoting from one of the annual reports of the Center, we included "increasing irritability in little things." Smiles of anticipation flashed across scores of faces. Clearly, these boys and girls looked forward to the pleasure of informing their parents at the moment of slightest reprimand that they had better get themselves to a clinic. We had to stress our conviction, as parent as well as clinician, that irritability with adolescent antics is not necessarily a sign of the imminent approach of alcoholism.

VOL. 11, NO. 1 INVENTORY MAY-JUNE, 1961

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

TEN YEARS of ALCOHOLISM EDUCATION

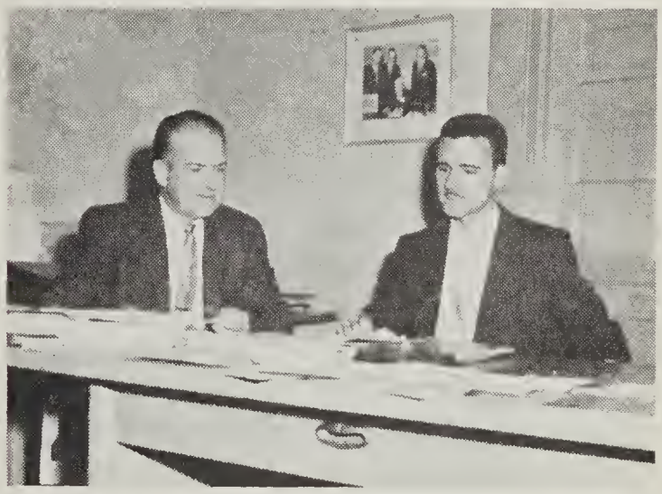
Though evaluation of education in prevention is difficult, there are indices of progress in N. C.

THERE was ample precedent in 1949 for establishing a program aimed at the prevention of alcoholism in North Carolina. Three decades or more of fruitful experience in attacking problems affecting the public health had gone on before.

Three sound and tested public health principles growing out of this experience—education, treatment, research—have been utilized by the North Carolina Alcoholic Rehabilitation Program during the past ten years to bring an understanding of the complex and widespread illness of alcoholism to the citizens of the state and to offer hope for recovery to those already suffering from alcoholism.

That North Carolina was one of the first states to establish an official program in the area of alcoholism, however, is a fact which bears witness to the insight and foresight of her leaders. The NCARP evolved as a result of an appropriation by the 1949 North Carolina Legislature for "establishing further treatment facilities for alcoholic persons and additional mental health activities for the prevention of alcoholism." The funds for its support are appropriated to the N. C. Hospitals Board of Control, governing body for the state's mental hospitals.

Planning The Educational Program



Norbert L. Kelly, Ph.D., Associate Director, and George Adams, Educational Director, of the NCARP.

The tenth anniversary of the North Carolina Alcoholic Rehabilitation Center, treatment facility of the NCARP, was observed last fall and noted in the September-October *Inventory*. A subsequent issue contained articles on the "Frontiers of Research" and future plans of the NCARP.

This issue commemorates the tenth anniversary of *Inventory*, bimonthly journal on alcohol and alcoholism, which is an integral part, but by no means the whole story, of the NCARP's educational program. With the "why" of *Inventory* having

been set forth in editorials appearing in this issue, the remainder of this article will be devoted to the "why" of the other facets of the NCARP's educational program.

The NCARP actively participates in three broad areas of education: public education, education in schools and colleges, and professional education. The ultimate goal of its educational program is prevention.

A look at the ramifications of the illness of alcoholism will suffice to indicate the magnitude of the task of prevention for which the chief tool is, at present, education.

It is strongly suspected and generally accepted that the roots of alcoholism are embedded in early personality and character development of the individual as well as his own attitude toward alcohol and that of the society in which he lives. The involvement of psychological and socio-cultural factors in alcoholism suggests that preventive education must be directed at achieving better mental health practices, particularly in the area of parent-child relationships, and modifying attitudes which help precipitate and perpetuate the illness.

The NCARP's educational program, then, seeks to do more than impart factual information about beverage alcohol and alcoholism. Its fundamental purpose is to promote better mental health and modify attitudes which enhance alcoholism to the end that the illness *is* prevented. The achievement of this purpose will require an all-inclusive long-term educational effort. Obviously it is unrealistic, for example, to expect attitudes that are deeply rooted in our cultural patterns to undergo quick and complete change in just a few years.

The educational program, however, while striving to achieve its ultimate goal, is expected to, and does, produce benefits or by-products of a more immediate nature. Included among these by-products are local alcoholism programs whose general purpose is to engage in educational activities, disseminate information, and provide referral services to patients at the community level. The NCARP, by working with interested citizen groups, has been instrumental in establishing North Carolina's present twelve local alcoholism programs.

Facilities and resources for the treatment and rehabilitation of our present alcoholic population and their families is another by-product of education. Such facilities have grown immensely in number during the NCARP's ten years of alcoholism education concurrent with the development of local programs and increased cooperation with other health and social agencies. Many doors are now open to help alcoholics and their families that were previously closed.

The public education program of the NCARP is both general and specific. Educational messages designed to help create an atmosphere of public understanding of the alcoholic as a sick person and recognition of alcoholism as a treatable, preventable illness are relayed to the general public via the mass media, pamphlets, brochures and other literature including *Inventory,* talks before community groups, and the use of exhibits, films and other educational tools. At the same time, the content is aimed at motivating action among specific individuals and groups within the public who are in a position to spot the early signs of alcoholism and do something about it. Included among these key individuals and groups are employers in business and industry, members of families of alcoholics and the alco-

holic, himself.

The "why" of participating in public school education is more and better instruction for the state's most precious resources—its children. To this end, the NCARP conducts summer school courses for teachers at colleges and universities and provides consulting personnel for planning and carrying out in-service training programs for teachers within the school system. In addition, supplementary materials for classroom instruction and reference materials for school libraries are available from the NCARP.

The schools along with the home and church are character building institutions. At school the child receives academic instruction concerning individual responsibility in health, government, and as a member of society. It is in this area of individual responsibility that objective information on alcohol and alcoholism is of vital importance because, in the final analysis, the use, abuse, or rejection of alcohol is an individual matter.

The child's original attitude toward alcohol, whatever it may be, is, of course, learned in the home. The school, as one of the child's first contacts with the outside world, can not prevent his eventual exposure to the diverse and often contradictory attitudes toward alcohol and alcoholism current in the Greater American Culture, but it can arm him at an early age with objective information as preparation for his individual and inevitable "hour of decision."

The schools, through parent-teacher organizations, offer the opportunity for working with parents as well as teachers. Since mental and emotional health is directly related to the prevention of alcoholism, the NCARP's educational program is also concerned with education in parent-child relationships and teaching both parents and teachers how to recognize signs of emotional maladjustment in children.

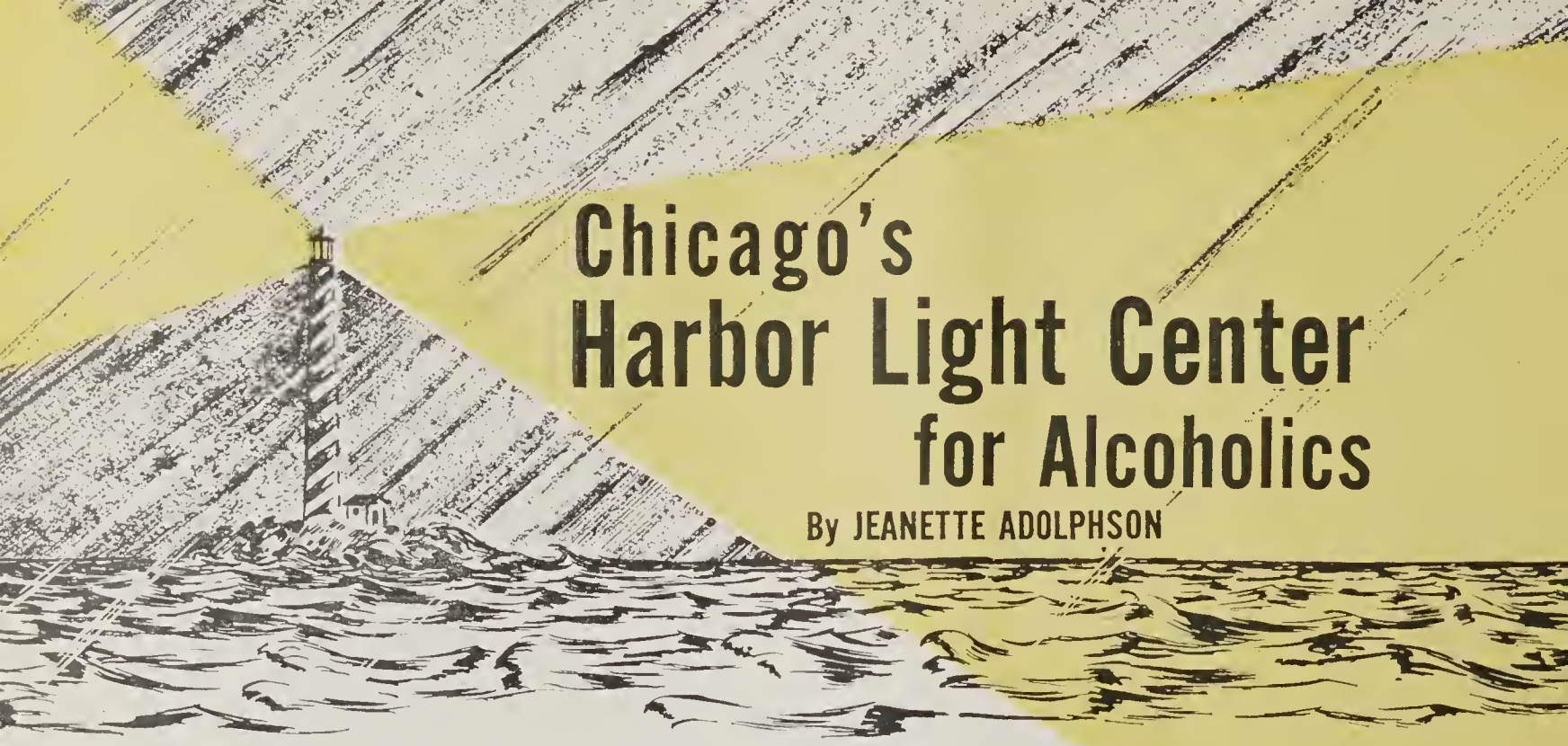
The NCARP's interest and efforts in institutions of higher learning are directed more at getting alcohol and alcoholism instruction in the curriculum of schools which train people in the helping professions such as medicine, nursing, public health, social work and the ministry.

What do the people in the helping professions who are already putting their skills to use in communities know about alcohol and alcoholism? What are their attitudes and feelings? The answers are the concern of professional education.

The practitioners of the professions named, as well as those of many others, are in a position to render services to alcoholics, yet the chances are that most of them received little or no instruction about alcohol and alcoholism in their professional training. To fill this gap and, at the same time, make the best use of a limited staff, the NCARP conducts and participates in summer school courses, seminars, workshops and institutes, and provides scholarships to the Yale Summer School of Alcohol Studies.

Indices of Progress

The effectiveness of an educational program, unfortunately, can not be adequately evaluated merely by volume of output. If this were true, the NCARP's educational program would surely be an unqualified success. There are, however, some indices of progress. During the past ten years the number of estimated cases of alcoholism in North Carolina decreased from around 60,000 to 52,000. And, best of all, there is increasing evidence that more and more of our citizens are becoming aware of the problem and forming action groups to combat it. (L. W. & J. R.)



Chicago's Harbor Light Center for Alcoholics

By JEANETTE ADOLPHSON

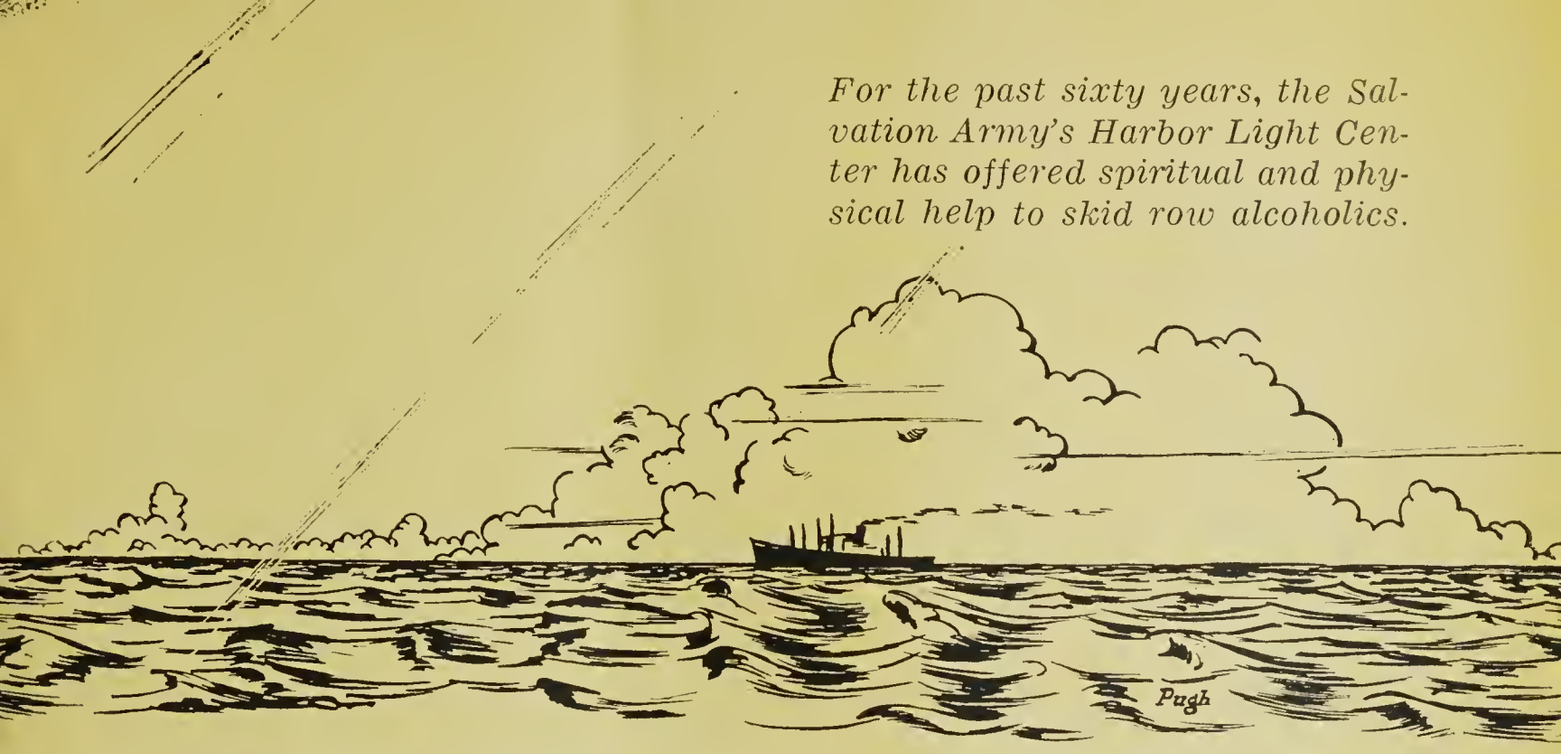
SKID Row—the term brings to mind the derelict, the alcoholic, the homeless. Our mental picture is that of an anonymous person, usually male. But the skid row resident is not anonymous. He may use an assumed name; he may have no contact with his family; but for himself, at least, he has very real identity and very real problems.

Chicago's West Madison Street skid row area has approximately 15,000 residents of whom 85% are moderate or heavy drinkers. Many of the others are elderly men, living on pensions, welfare checks, or social security payments. It is primarily a man's skid row for one sees fewer women here than in other skid row areas of the city. Taverns open early and close late. Jackrollers often carry on their activities during daylight hours with little fear of interruption or arrest. The police paddy wagon makes its routine rounds to pick up the most inebriated and take them to jail for an overnight stay in the "drunk tank", knowing that many of the men will return to their drinking as soon as possible after being discharged from court the following morning.

What does the future hold for these alcoholics? Is there any hope for their rehabilitation? The personnel at the Salvation Army's Harbor Light Center on the West Madison Street skid row believes there is hope, and they are ready to help those who come to them for help.

Harbor Light Center has, since its beginning some sixty years ago, offered spiritual and physical help to the alcoholic. As a means of helping these men HLC has established a residential rehabilitation program with dormitory facilities for 140 men. The staff directly responsible for the operation of this program (personnel manager, building managers, dormitory managers, employment manager and counselors) are themselves recovered alcoholics.

An applicant for admission to the program is first interviewed by a counselor to learn something of his background, his sincerity in desiring rehabilitation, and whether or not this particular man would benefit from the program. If it is felt that the man would benefit more from one of the Salvation Army's Mens' Social Center programs than from HLC's program, he is referred to one of these. Once a man is admitted, he is assigned a counselor and is encouraged to discuss any problems or difficulties with him. He is also given a work assignment around the dormitory or corps for 7-10 days. If he has been on a prolonged drinking bout just prior to entering the program, or, if he is ill, the assignment is delayed. Usually he works



For the past sixty years, the Salvation Army's Harbor Light Center has offered spiritual and physical help to skid row alcoholics.

only a few hours a day, in return for which he receives his room and board. This period serves as a time for the man to get back on his feet physically and to become oriented to life at the Center.

After working around HLC for this initial period of time, the individual is put on the worklist and works outside the Center. He may obtain a job on his own initiative or may be assigned a job through HLC's employment office. This is a step towards helping him assume responsibility again, for he now pays a moderate amount of rent and also pays for his meals.

As long as he does not drink, he may continue to live at Harbor Light; and some men have stayed for several years. However, the purpose of the program is to rehabilitate the man and help him become established once again as a productive member of society, able to live in sobriety away from the sheltered environment of Harbor Light.

Men who leave the program giving notice of their destination and future plans are considered as leaving in good standing. Those who leave without explanation are considered AWOL; and those men who leave because of their drinking are called DOA. Approximately 25% leave in good standing and the majority of them are believed to maintain sobriety; but the tendency of most of these men to move frequently makes follow-up difficult and therefore no long-term statistics are available. There is no limit to the number of times a man may enter the rehabilitation program, as long as it is believed that he can benefit from it.

The Salvation Army believes that in his battle for freedom from alcohol the alcoholic has in God his most powerful and faithful ally. The spiritual dynamic of God's power can do more than just relieve, recover, or rehabilitate; it can change the whole man. In working with alcoholism, the Army seeks to relate its spiritual program to today's scientific and medical approach. Consequently, Harbor Light's work is enlarging and the scope of services available is increasing. Three years ago an experienced social worker was added to the staff; and shortly after, with the aid of funds from the state's Division of Alcoholism, a medical and psychiatric clinic was opened.

The skid row resident is hesitant to seek help outside the skid row area. He does not feel free to attend private clinics elsewhere even when he can afford it. To do so means to expose himself to the unfavorable reactions of others attending such clinics. He is out of place in such a setting and he knows it. To attend

a free clinic outside the skid row area often holds the same risks. Then, too, he is reluctant to spend the $.25 for carfare ($.50 round trip). He too often feels his illness is not severe enough to warrant such misuse of his money—his next drink is most important! Knowing this, the Salvation Army knew that the men would welcome a clinic which would serve them in their own neighborhood.

The medical clinic is staffed by two part-time physicians (one of whom is medical director), one full-time nurse, and one part-time nurse. The psychiatric clinic is staffed by a consulting psychiatrist, a part-time psychiatric social worker, a psychologist caseworker, and a social worker.

Services Free

Finances were, and are, a problem; and it was necessary to appropriate space already in use for other purposes. The offices of the psychiatric clinic workers are in the Harbor Light Center building and the medical clinic is located on the first floor of a nearby hotel, in rooms formerly part of recreation facilities for men in the program. All services are free and available to men in the program, men from the local area, or men referred from other agencies. There is no in-patient service as such, but a sick man needing shelter for a period of two or three days may be housed by the Army at their nearby Red Shield quarters (53 beds leased from a hotel and used primarily as lodging for transients or men waiting to be admitted to the rehabilitation program.)

The psychiatric clinic is directed toward helping the men to solve their mental and emotional conflicts and maladjustments, factors which contribute to their alcoholism. Both individual therapeutic counseling and group therapy sessions are offered. The first interview is frequently used for winning a patient over to accepting and wanting treatment service. After he has shown his willingness to continue therapy, a different type of interview is used. However, the goals of therapy must often be limited to solving immediate problems rather than resolving underlying psychologic and emotional disturbances. Some men have remained in therapy for weeks or months while others have come in for only one visit. Many men make appointments which they fail to keep; but some of these will later come in without appointment, on the chance that the therapist might be free to see them. The longer the period of time the man continues in therapy the greater the opportunity to observe any progress. Some men in therapy have interrupted their drinking pattern for a longer period of time than had been the case for months or years. Others seem to be gaining insight into their problems but show no change in their drinking pattern. In a small number of cases there has been evidence that the man has had a prolonged interruption of his drinking and also that he is making progress in his adjustment to his problems.

Three group therapy meetings are available to the man. The psychiatric social worker conducts a "recreation group" which concerns itself with discussion of constructive use of leisure time. Many of these men feel that when not drinking and away from skid row they are prevented from establishing real roots in a community because the public distrusts them. They feel that others regard them with an attitude of "I wonder when he'll start drinking again"; and since they are not accepted as full members of society, they feel pressured to return to the tav-

erns (and eventually skid row) for companionship and understanding. The psychologist caseworker leads an open discussion group, with each meeting open to whatever those present wish to discuss. The social worker is in charge of a "prayer and fellowship group" in which those attending share individual needs and concerns in prayer and meditation. Attendance at group meetings is usually limited to eight, a number which permits free discussion and participation of all present. Some of the men avail themselves of both individual and group therapy, but many who attend the group meetings do not enter individual therapy. The group meetings have been especially beneficial at Harbor Light because they enable the small staff to serve a greater number of people meaningfully than could otherwise be done. During this past year the psychiatric clinic staff had an average of 145 individual counseling sessions and 11 group therapy sessions monthly.

Medical Clinic Enlarged

The medical clinic originally had only 448 square feet of floor space which was divided into three rooms —a small waiting room, a consultation and examining room, and a medication and treatment room. Last fall the clinic was enlarged by 144 square feet to provide a separate room for treatments and remodeled to provide a private examining room. Despite the limited space, 2,958 individual men were treated during the first 25 months the clinic was open. The average monthly caseload was 500. Approximately half the men seen are in the rehabilitation program at Harbor Light and the other 50% are from the local area or referred from other agencies. An effort is made to treat the "whole man" (i.e., his physical, mental, emotional, and spiritual needs) but this often is difficult because of the heavy caseload and because of the reluctance of many of these men to discuss personal information.

The most common illnesses seen and treated are traumatic and stasis ulcers, delirium tremens and withdrawal syndromes, chest pathologies, lacerations and traumatic injuries, peptic ulcers, hypertension, malnutrition, and arthritis. Little suturing is done for most men come in for treatment only after a wound becomes infected. Often the patient admits that he was drunk and does not know when or how the injury occurred. When the pain is sufficient to penetrate his alcoholic anesthesia he will seek treatment. Patients needing hospital treatment (either in-patient care or out-patient services such as x-ray or laboratory work) are referred usually to Cook County Hospital or one of the nearby Veterans hospitals. Some of the more simple laboratory tests are done at the clinic.

In treating withdrawal syndromes, tranquilizing medicines are usually given. The lack of facilities for in-patient treatment creates some special problems, particularly the possibility that a patient might combine drinking with the medication, so the following basic rules have been established: The patient must have a place to stay, preferably at the Salvation Army's Red Shield quarters. If the patient is staying elsewhere, this is verified, usually by a telephone call to the hotel he names. Also, he must be able to understand the instructions regarding the time at which the medicine is to be taken. If the patient is staying at Red Shield, the medicine is given to the manager who sees that it is taken as directed. All men receiving treatment for withdrawal from alcohol are escorted to their place of lodging

by one of the men in the Harbor Light program. Not more than a 24 hour supply of medicine is given except on weekends when a 48 hour supply may be given if indicated. The most frequently used tranquilizer is Sparine 50 mg. tid or quid. If additional medication is needed for sleep, Mebaral or Doriden is given. Few men indicate that their symptoms were not relieved by the oral administration of a tranquilizer. A number of patients will refuse further medication on the second day, stating that they no longer need it; however, most men will require the tranquilizer for 2 or 3 days. Only rarely is medication required for a 4th or 5th day. Many men seem to take pride in the fact that they can sober up without medication or with the use of tranquilizers for only one day.

Common Characteristics

What characteristics seem to be common among these men? One characteristic is the lack of a sense of humor, especially the ability to laugh at oneself. Another is that of being in a hurry even when there are no appointments to keep or deadlines to make. This is especially true of the men who come from outside HLC. This hurry is often caused by the patient's fear that one of his friends might have a bottle and he is missing out on the drinking. But one rarely encounters a difficult patient for even the most inebriated wait quietly.

Another common characteristic is the lack of long-term goals. This is sometimes graphically illustrated by men in the rehabilitation program. Some men will stay at HLC for several months and during that time save several hundred dollars. Then they start drinking again, seemingly feeling that there is no good reason for continuing to work and save money. Some men deliberately keep themselves financially broke because they *know* that if they have too much money available, the temptation to start drinking again will be too strong for them to resist.

The age range of patients seen in the medical clinic is from 16 to 84. The average age of the patients is 43½, but the largest single age group is the 38 year old group, with the 39 year old comprising the second largest group. Forty percent of all patients are between the ages of 36 and 41. Of the total of 2,958 patients treated during the first 25 months of the clinic's operation, only 15 were female, and 8 of these were Salvation Army employees. Thirty-two patients were Negro; 29 were American Indian; and only 1 patient was known to be of Jewish background. Forty-one percent of all patients are veterans, but 77% of the patients under 30 years of age are veterans. Seven percent of the total number of patients are under 30 years of age, and 1 out of every 6 or 7 of these comes to the clinic for treatment for withdrawal from alcohol. One twenty-eight year old patient has made ten visits for treatment for withdrawal syndromes. Only 1.7% of the patients are over 65 years of age, and none of these has needed treatment for withdrawal syndrome. Many patients coming to the clinic are seen only once or twice; but a large number have continued for long-term care or have returned many times for treatment of various illnesses. One patient has made over 80 visits.

Since the opening of the medical and psychiatric clinics, the percentage of men leaving Harbor Light in good standing has increased 4 to 5%. Whether or not this is a result of the clinic services is not known. However, there are numerous instances where individuals seen over

a period of time have shown definite evidence of benefiting from the clinics.

One such man is Martin V. who came to the medical clinic asking for help in withdrawing from alcohol. Martin had only recently come to skid row after having been divorced by his wife because of his drinking. Since it was necessary that Martin have a place to stay before such medication could be given, arrangements were made for him to stay at Red Shield. Martin returned to the clinic for medication for 3 days, meanwhile continuing to live at Red Shield.

Improved Outlook

Through this contact he became acquainted with the rehabilitation program and applied for admission. Soon after entering the program, he began individual therapeutic counseling sessions. As he gained self-understanding, he was able to bring his goals into more realistic alignment with his abilities and circumstances than he had formerly done. Instead of vainly trying to win back his ex-wife's affections, he learned to accept the fact that she was soon to marry someone else. Also, he had long resented anyone with whom he worked who was promoted to a more responsible position than his own since he felt that he was as capable at his trade as anyone. On his own initiative he enrolled for special educational courses so that when an opportunity for promotion came he would have both ability and education in his favor. Within a few weeks, he was again regularly employed and had to interrupt the therapy but came in for individual sessions as often as his schedule would permit. After a year, he moved out of the dormitory, leaving in good standing and maintaining contact with HLC through attendance at the Sunday chapel services and through occasional contact with the therapist.

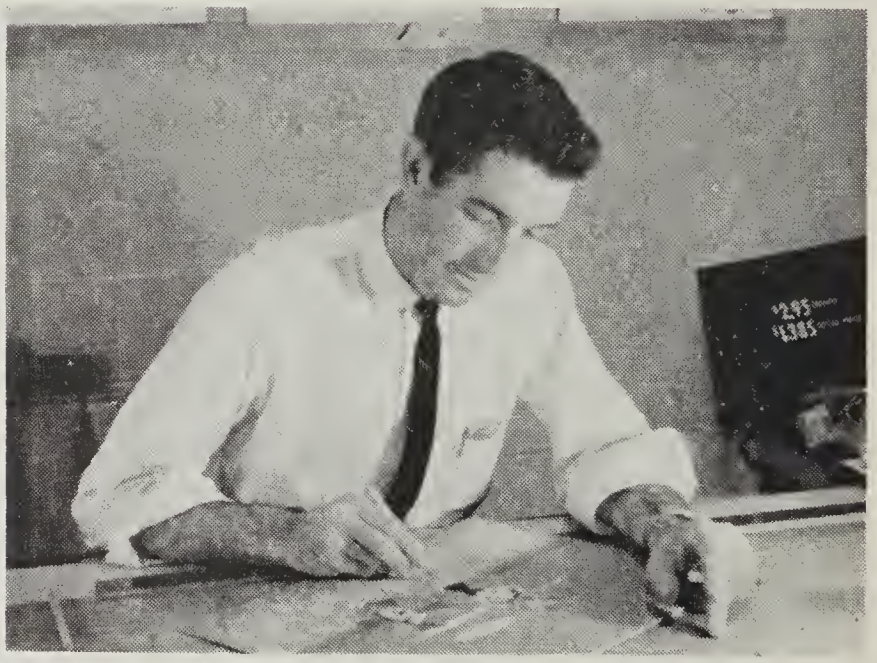
After four months he started drinking again and returned to HLC for readmission to the program and for medical treatment during the withdrawal period. He stated that he believed he had overestimated himself in not realizing that he still needed the psychological support of the Center and of his therapy sessions. The realization that he still needed such support seemed to give him added insight into areas in which he needed particular help. This time he stayed at HLC for six months, during which time he used his therapy sessions to much advantage, thinking through the necessity of transferring his dependence on HLC, its program and personnel, elsewhere if he planned to again move out of the dormitory and was unable to keep in regular contact. Now, three months after leaving HLC again, he feels he is ready to establish roots in his present community and gradually decrease his dependence on Harbor Light.

James K. first entered the rehabilitation program 20 months ago. A widower who had little contact with his children, he had drifted from one city to another since his wife's death two years before. He would work for a short while, then become despondent because he no longer "had anything to live for" and try to forget his loneliness by drinking for prolonged periods of time. Eventually, he found himself in Chicago on West Madison Street, moneyless and with no place to stay. Knowing about the Salvation Army's services to those in need, he came to Harbor Light Center. After talking with a counselor and learning about the rehabilitation program, he decided he would try it.

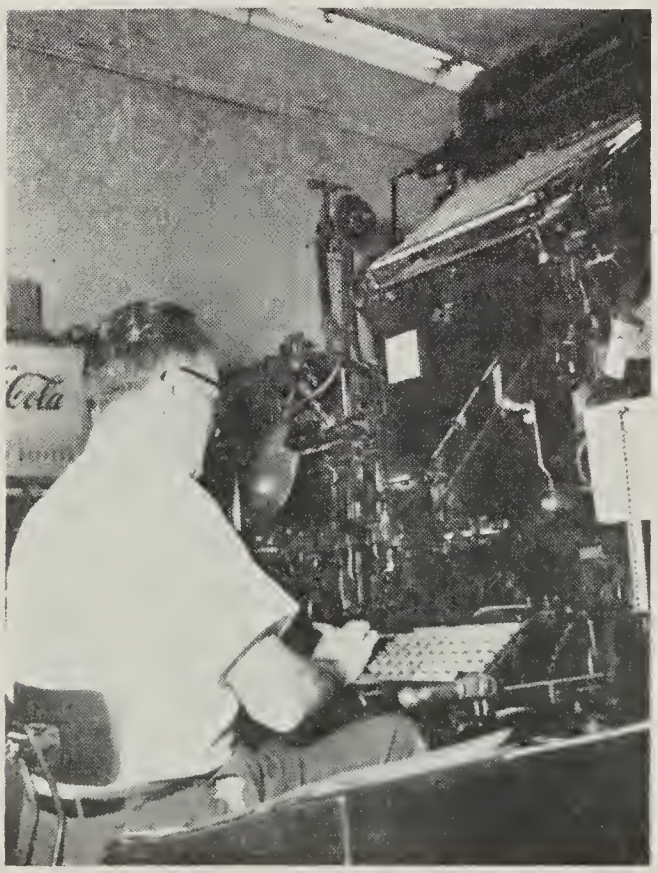
(Continued on page 18)

Inventory — FROM START . . . .

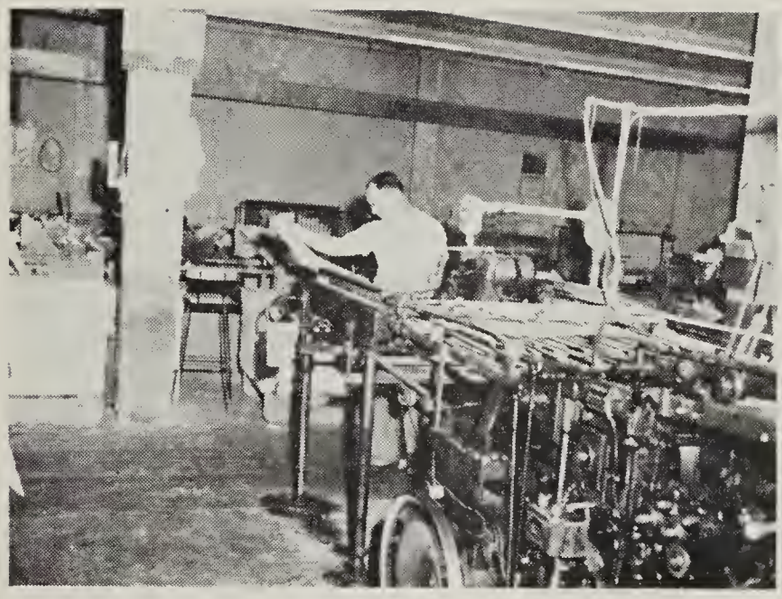
Editors Lillian Wilson and Jackie Ransdell select and process copy with appreciation to INVENTORY'S many contributors.



Artist Bill Pugh translates ideas into picture language in collaboration with the editors.



Linotypist Bob Stanley of the GRAPHIC PRESS sets the type.



Pressman Lloyd Hendricks
keeps the press
running smoothly.

Meanwhile, circulation manager
Eleanor Brooks
runs off the mailing list
on addressograph labels.

Dewey Massey and
Milton Thompson
attach your label to a copy
and deliver it
along with 18,965 others
to the post office
from whence it reaches you.

. . . . . TO FINISH

Harbor Light

(Continued from page 15)

He, too, entered therapy but continued for only four sessions.

He remained at Harbor Light for eight months and left in good standing with a regular job. However, he did not keep in contact with HLC. After three months he started drinking and drank heavily for ten days before returning to Harbor Light. When he came to the medical clinic for treatment, he explained that he had started drinking because he was working too hard. After paying his hotel rent he had little money left for food. With little free time to look for a better paying job and afraid to quit working without some prospect of future income, he finally became discouraged and decided to go out and get drunk. He also explained that he had been "too proud" to come back to HLC and ask for help while he was still working, although he would have liked to move back into the dormitory and take advantage of the low rent and food prices; and he was "too proud" to come back after he started drinking because he didn't want the other men to know about it. But he finally realized that he should come back and start over.

That was ten months ago and James is still living at HLC. He has not re-entered therapy, but is active in the various phases of HLC's program. He has re-established regular contact with one of his sons and finds joy in discussing the doings and sayings of his grandchildren. He has no immediate plans for moving out of the dormitory because he finds that the close contact with the other men and the personnel of the Center makes his periods of despondency less frequent and helps him to overcome them when they do occur.

Robert C. came to Harbor Light through contact with a friend, also an alcoholic, whom he had met several years ago when both were receiving treatment for alcoholism in one of the state hospitals. Two months after entering the program, Robert started individual therapy sessions and continued in therapy until he had to leave HLC five months later because he started drinking again. He was seen at the medical clinic only a few times during this time.

After two prolonged drinking bouts and eight weeks' hospitalization, he then, through contact with the same friend who had originally brought him to HLC, applied for readmission.

During his first six weeks back at HLC he was seen several times a week in the medical clinic, receiving treatment for withdrawal from alcohol and for malnutrition; and it was learned that he also needed treatment for peptic ulcer. Robert believes that the greatest factor in his sobriety is neither medical nor psychiatric treatment, but his conversion experience which occurred shortly after he returned to HLC. As a result of the spiritual dynamic he now knows he has been able to maintain sobriety for a longer period than he was able to do at any time during the last fifteen years.

ABOUT THE AUTHOR

Mrs. Adolphson presently serves as a full time nurse with the Salvation Army's Harbor Light Center for alcoholics on West Madison Avenue in Chicago. She attended Bob Jones University in Greenville, S. C. and is a graduate of West Suburban Hospital School of Nursing in Oak Park, Illinois. She holds a B. S. degree in Public Health Nursing from Loyola University in Chicago and attended the Yale Summer School of Alcohol Studies. Following 16 months of work with alcoholics at the Pacific Garden Mission in Chicago, she joined the staff of HLC.

INDEX of INVENTORY

Bi-Monthly Journal on Alcohol and Alcoholism

MAY, 1951 THROUGH MARCH-APRIL, 1961

An index will be published yearly in each succeeding March-April issue.

* Incorrectly listed on cover as Vol. 3, 1953, No. 1.

** Incorrectly listed on cover as Vol. 3, 1953, No. 2.

I

I-1 INDEX OF AUTHORS: BIOGRAPHICAL SKETCHES OF AUTHORS AND PERSONALITIES (The keys following names will lead to categories where articles by that author will be found. Biographical sketches are indicated by Vol./No./Year: Page.)

a

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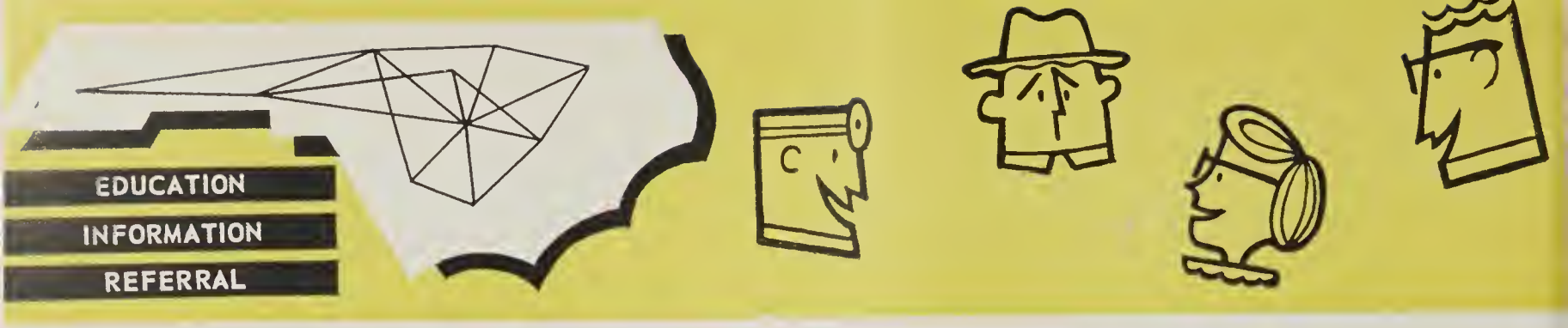


Currently In North Carolina there are twelve

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—
Citizens' Committee on Alcoholism
Rev. Robert L. Torrence, Chairman
50 College Street, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellerman, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
209 Snow Building—Phone: 2-5227
Mrs. Olga Davis, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade— Phone: BRoadway 4-1295
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714
or GEneva 8-4730
Vance County Health Center,
P. O. Box 233
Rev. Edward Laffman, Director

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
119 N. Scales St., P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public libarary to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

VOL. 11, NO. 2 JULY-AUGUST, 1961

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

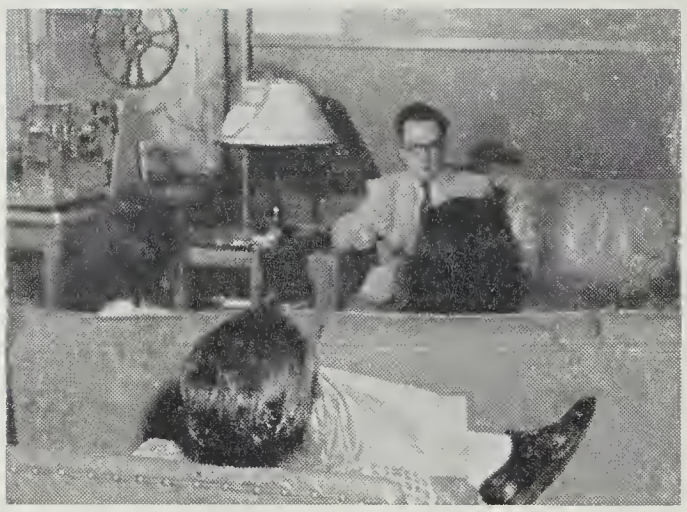
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 11 NUMBER 2

JULY-AUGUST, 1961

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

LILLIAN WILSON
Editor

JACKIE RANSDELL
Assistant Editor

ELEANOR BROOKS
Circulation Manager

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: The North Carolina Alcoholic Rehabilitation Program recently awarded 21 scholarships to the Yale Summer School of Alcohol Studies in New Haven, Connecticut. This is the last such course that will be taught at Yale and it will be in session from June 25 through July 20.

ALCOHOLISM AND CIRRHOSIS: The mortality rate in the United States for cirrhosis of the liver among alcoholics is about 650 per 100,000 per year, it was reported in "World-Wide Abstracts." The mortality rate has increased from 9.2 per 100,000 in 1948 to 11.3 in 1957. In New York City, cirrhosis is the fourth highest cause of death between ages 25 and 65. It is responsible for 6 percent of all deaths between 25 and 44. Biopsies have shown that among people who have been heavy drinkers for five years, 50 percent have abnormal livers; after ten years of heavy drinking, 90 percent have abnormal livers.

DURHAM, N. C.: The fourteenth annual convention of North Carolina Alcoholics Anonymous was held recently at the Jack Tar Hotel in Durham, N. C. Approximately 750 members of A. A. attended the 3-day gathering. There are nine districts and 125 A. A. groups in North Carolina with 3,000 members.

LANSING, MICHIGAN: The Michigan State Board of Alcoholism has recently published an attractive pamphlet called "I've Got Ethyl on My Mind." This pamphlet presents, by means of graphic illustrations, facts and figures about ethyl alcohol and its effect on the body. The pamphlet is a project of the Department of Public Instruction Curriculum Committee on Alcohol Education. It will be available for general distribution at the beginning of the next school semester.

RALEIGH, N. C.: A two-week study course, Summer Studies on Facts About Alcohol, for teachers and student teachers was recently concluded at three North Carolina colleges: North Carolina College, East Carolina and Catawba. Two ARP staff members, associate director Dr. Norbert L. Kelly and educational director George H. Adams, joined several college officials in conducting the sessions. Approximately 145 teachers attended the summer schools at the three colleges.

BUFFALO, NEW YORK: Alcoholism is not hereditary but it is communicable, reports Dr. Marvin A. Block, chairman of the American Medical Association's committee on alcoholism. He says that 50 percent of all alcoholics have had alcoholic parents, and that alcoholism produces the kind of tension in a home that is apt to drive the children to alcoholism later in life.

RALEIGH, N. C.: A $45,000 appropriation was recently approved by the North Carolina legislature to help promote the development of community alcoholism programs in North Carolina. The funds will be administered by the North Carolina Alcoholic Rehabilitation Program and will be used to match funds raised by individual communities for the establishment of local alcoholism programs. North Carolina already has 12 local alcoholism programs, and it is hoped that this positive step by the legislature will stimulate additional citizen interest and action in establishing many more community alcoholism programs.

NEW ORLEANS, LOUISIANA: The twelfth annual meeting of the North American Association of Alcoholism Programs will be held November 5-9, 1961 at the Sheraton-Charles Hotel in New Orleans. The theme of the meeting will be "Administering the Work of Alcoholism Programs With Related Services."

ALCOHOLISM FILMS: The Salvation Army's 20-minute color film, "The Big Return," is now available for public showing. The film depicts the efforts being made by the Army to secure a deeper public understanding of the problems an alcoholic faces—not only during the treatment program but during the readjustment period following his recovery. Many state alcoholism programs have excellent films which they will lend, free of charge, to individuals or groups desiring them. The Division on Alcoholism of the New Hampshire State Department of Health in Concord, N. H. has an especially good library. And, the NCARP offers many excellent films which are available free of charge from the N. C. State Board of Health in Raleigh.

CARRBORO, N. C.: The Alcoholism Information Center of the Orange County Council on Alcoholism recently opened its offices in the Carrboro Town Hall. The Center is designed to serve the entire Orange County area, and office hours will be held on Mondays in Hillsboro from 9:00 a.m. to 12:00 noon in the Public Health Department of the Orange County Courthouse, and on Tuesdays from 9:00 a.m. to 12:00 noon in Carrboro. Mrs. Margaret Rallings of Chapel Hill, executive secretary, will be in charge of the Information Center.

RALEIGH, N. C.: The North Carolina Alcoholic Rehabilitation Program recently joined with the State Employment Security Commission in sponsoring five all-day institutes on counseling and employing the alcoholic. Dr. Norbert L. Kelly and George H. Adams, ARP staff members, participated on the program which was designed especially for employment security interviewers, counselors and supervisors, and for vocational rehabilitation and industrial personnel. Institutes were held in Raleigh, Asheville, Washington, Charlotte and Greensboro.

Share Inventory

Would you please put us on your mailing list for your fine publication, *Inventory?* My wife and I are both alcoholics and will pass your magazine along to our many alcoholic friends.

Anonymous
San Jose, California

Anniversary Congratulations

My sincere congratulations on your tenth anniversary. We have been grateful recipients of *Inventory* for the past six years. Each addition is more interesting and informative. It has a special place in our library file and also for research projects.

May the next decade be as successful and productive as the last.

Sister Mary Kieran
St. James Mercy Hospital
Hornell, New York

Needs Information

Would you please include my name on your mailing list for your publication, *Inventory*?

I am a Sunday School teacher of young adults and need more information on the alcoholic problem.

Mrs. Jeff D. Ferguson
Spottsville, Kentucky

Teacher Writes

As an eighth grade science teacher, I have received *Inventory* for years and have used it in teaching Alcohol Education in General Science. I have thoroughly enjoyed reading it and have received a lot of help from it in preparing to teach this unit.

I do not plan to teach in the public schools next year and would like my name and home address to be placed on your mailing list, as both my husband and I are called upon from time to time to talk with members of our church family who have problems with alcoholism. I would also appreciate receiving copies of *Alcohol Education, Facts About Alcohol* and several copies of *Alcoholic's Are God's Children, Too.*

Mrs. Doris B. McNeill
Fayetteville, N. C.

Recommends Magazine

In my practice as a physician, I am often called upon to cope with problems of alcoholism in my patients and in their families. I wonder if it would be possible to obtain a few copies of the *New Cornerstones,* your family manual on alcoholism, so that I might distribute these among the patients and their families. I am already on your mailing list for *Inventory* and I find it most helpful to me. I recommend it highly to all of my patients.

Paul E. Jones, Jr., M.D.
Concord, N. C.

Help For Problem Drinker

I would like very much to be placed on your free mailing list to receive *Inventory.* I have a drinking problem and I feel that your magazine would be very helpful to me.

Anonymous
Bailey, N. C.

VOL. 11, NO. 2 INVENTORY JULY-AUGUST, 1961

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

OVERDEPENDENCE AND ALCOHOLISM

BY PERCY M. SESSIONS

CHIEF PSYCHIATRIC SOCIAL WORKER, BIRMINGHAM CLINIC
ALABAMA COMMISSION ON ALCOHOLISM

An individual overprotected by his parents and dominated by his spouse may turn to alcohol to fulfill his unmet needs.

TO many people the alcoholic is a person disinherited by his parents, cast out of his home by his family, and fired by his employer. They see him without friends, sitting alone on a park bench or incoherently talking with casual acquaintances at some smoky bar. They visualize him as dirty, unshaven, and generally unkempt. They see him furtively stowing himself away in some empty freight car as he filches a ride to some destination chosen without rhyme or reason—or perhaps with rhyme but certainly without reason.

While this is a realistic picture of many alcoholics, for every person whom this description fits there are others for whom it does not apply at all. Many are faced with abundant fruitless concern instead of neglect.

Among the patients seen in treatment clinics, many give histories of having been looked after, controlled, disparaged, and protected from reality by their parents until it was impossible for them as children to learn what life is like. Many of them had their every wish gratified in so

far as this was possible and were carefully shielded from the necessity of sustained efforts to achieve goals in life. They were never accorded the opportunity to make significant decisions, as these were made by the parents. The parents appeared to feel that they had to supply their children from their resources, judgments, and capacities for frustration.

Dominating Spouse

Naturally these children grew up with exaggerated dependency needs, and many of these men attracted and married women who were looking for men who could be placed in the inferior and dependent marital role. There are women who, because of their own childhood experiences, are distrustful of strong, aggressive men. They feel secure and comfortable only in situations where they can gratify their needs for mastery and domination. They make sure, therefore, that their over-protected, dominated, or too-much-looked-after husbands go right on having their decisions made for them. Often, furthermore, these are women who have somehow acquired the conviction that they themselves must be made to suffer—this for the sake of ultimate salvation—and they know that dependent, unstable, or alcoholic husbands can be the means by which the price of suffering is paid.

Probably, however, many more of these boys grow up and marry women of very different natures. Some of these women are simply looking for husbands and are thankful for any reasonably acceptable man who can fill the role. Many others are fastidious and idealistic in their selection of husbands and only later become aware of their mistakes when their husbands make it quite clear that they are more interested in alcohol than anything else. Then these women are forced to make a decision either to leave their husbands or find new ways to derive satisfactions from living with them. They frequently choose to continue the marriage; the satisfactions they then learn to enjoy are those of a martyr. Contrary to their original desires, they take the dominant position in the family and begin making the important decisions. This forces their husbands into the background.

There is a substance more potent than any parent or wife in shielding one from reality. This substance is alcohol. Often the too-much-looked-after child is ominously warned and direfully threatened about the use of alcohol. He is told so many terrible things about it that even he with his frail ego begins to suspect that not all he is told is likely to be true. Besides, there is something intriguing in his parents' attitudes toward alcohol. Here they are—these self-sufficient adults who have so many resources and such infallible judgements that they have never allowed him to use his own. Alcohol is one thing which apparently even they fear. They seem to be threatened by it. If only he could frighten or threaten them! What does alcohol have that he lacks? If he should ingest alcohol, perhaps he would then have it, also.

Symbol of Rebellion

Every adolescent rebels against parental authority. Sometimes the rebellion is so mild as to defy observation; sometimes it is not so mild. If his parents neither pursue alcohol with relish nor flee fearfully from it and have no strong feelings about his eventually drinking, obviously his drinking is not effective as an expression of defiance. He must find some other way to indicate to his parents that their authority over him

has expired. If his parents themselves drink but forbid him to do so, or if in addition to forbidding him to drink, his parents give evidence of cringing at the mention of alcohol, then his drinking becomes a singularly bold and attractive act of rebellion. Imagine his feeling of triumph at being able to embrace without fear a substance which has the capacity to shock and intimidate his parents!

Puppet on Strings

Having been prepared by his total life experience to embrace alcohol with zest, our alcoholic is soon lost in its influence. Always he has resented having to be dependent on others, living as a puppet on strings pulled by his parents and then often by his wife, also. He has resented, too, not being allowed to assume the role of an indivdual, being required, instead, to sharply bridle and suppress his own capacities for judgment, assertion, and masculinity. Alcohol shows him a way to free himself from the control of others. In a way, he is finally emancipated. No longer does he have to look to his parents and his wife to protect him from reality; he can depend on alcohol, instead. The latter does for him precisely what they have done, except that alcohol does it much more effectively. Besides, if he has been forbidden to drink, alcohol is an effective means of passive defiance and rebellion. Should he undertake to express his defiance in any other way, his own will would be overwhelmed by the reactions of his parents or his wife. Therefore, he will get drunk, and, no matter what their reactions are, he will remain not one whit less intoxicated. For the first time, he has found a substance of strength—strength to resist the pressure with which he is plied by his "superiors."

The response of those who have so long controlled him is to intensify the protective, controlling, and dominating measures. He must be protected from himself and his friends, from alcohol, and from the consequences of his drinking. He must be further forbidden to do and say things, because these things cause him to get into such a frame of mind that he ends up drunk. John Smith, Tom Jones and Joe Bloke have been taking him off and getting him drunk. He must be positively forbidden to associate with them ever again, and they must be told to leave him alone. You can never tell what bad company he will be associated with when he goes fishing or golfing. Therefore, he must not be allowed to go any more. He must remain where someone can keep an eye on him. Somebody must tell him to leave that awful stuff alone or to drink like other men, never to excess. When he gets drunk anyway, he must be helped home and put to bed. His bottle must be emptied into the sink lest he empty it himself into his already saturated person. He must be forced to drink coffee and to eat something in the hope that this will sober him. Somebody must call his foreman and explain why he is not at work—describe the illness that has again confined him to bed. What illness should it be this time? Somebody must procure a bottle to replace the one that has been emptied because he needs one now for tapering off purposes and to relieve his suffering. Anyway, it is better to put up with his drinking at home than for him to be pulling out for heaven knows where.

Objectionable Attention

Or perhaps he cannot be helped home because he is simply not to be found in the usual dives. The town, consequently, must be searched from

A Street to Z Avenue. Then perhaps he is found in jail. He must be gotten out of there immediately, because it is simply terrible for him to be in such a place. After all, he might be seen and recognized there. What would the neighbors think? Somebody must pay his fine, because the poor boy has no money for the purpose. The preacher must be called in to save his soul, the doctor to prescribe, the social worker to give support to the family. Certain relatives and friends must never know; but other relatives and friends must always be told, because they are so understanding and so ready to show their appreciation for the awful ordeal that these loved ones of the alcoholic are having to endure. They are so ready to concede that were it not for the marvelous patience, strength, and long suffering of the parent or wife, the whole situation would have long since gone to hell. The alcoholic must be nursed back to health, lectured, remonstrated with, prayed for. Perhaps he can be controlled with threats—some threat not used before—or perhaps one of the old threats will be more effective this time.

In a way, this attention is highly objectionable to the alcoholic. It involves having people do things for him and inconvenience themselves on his behalf. From his point of view, this puts him in their debt. He feels that he owes these people something in return for their efforts, and he resents being indebted to them or to anybody else. He feels that he already owes too much—so much that he needs a drink to forget about it. Furthermore, the sacrifices that these people make for him are repulsive because he suspects that somewhere in them there is a hook fashioned for his mouth. Why have they put themselves out to do favors for him? It appears to him that they want to put him in their debt. They help him because they want him to do something for them in return. Should he not be able to pay off, they will be much annoyed with him. Their helping him, moreover, is just another way of telling him that he is not adequate, that he is not able to take care of his own needs, that he is just not really a man. These are the people who have done things for him—things he himself wanted done at the time—and he felt momentarily grateful. But these are the people who also keep reminding him of his own inadequacy and tempting his weaker self. He never knows whether he would sink or swim on his own efforts, because whenever he is subjected to the test, they help him to cheat. They conspire with his weaker, more dependent self to prevent the assertion of his independence, masculinity, or manhood by his stronger, better self. His momentary gratitude then slowly, and sometimes rather abruptly, turns to resentment and even to hate.

On the other hand, the alcoholic loves all this attention. It even justifies additional binges. Once he was a nobody, not even being allowed to assert himself. What he said or did never influenced other people. But look at him now! All of the attention he gets now must surely prove that he is a somebody. Granted, he is not a somebody who is admired, but neither is he any longer a nobody who is ignored. Of course, he is still often controlled and pushed around, but this is no longer done in a thoughtless and off-handed way. And at last he has found a way to retaliate and to do some controlling and pushing around on his own.

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The Language of the Heart

BY BILL W.

The co-founder of Alcoholics Anonymous describes how a unique communications system has enabled A. A. to spread throughout the world.

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MY workshop stands on a hill back of our home. Looking over the valley I see the village community house where our local group meets. Beyond the circle of my horizon lies the one world of A.A.; eight thousand groups, a quarter of a million of us. How in twenty-five years did AA get the way it is? And where are we going from here?

Often I sense the deep meaning of the phenomenon of Alcoholics Anonymous, but I cannot begin to fathom it. Why, for instance, at this particular point in history has God chosen to communicate His healing grace to so many of us? Who can say what this communication actually is—so mysterious and yet so practical? We can only partly realize what we have received and what it has meant to each of us.

It occurs to me that every aspect of this global unfoldment can be related to a single crucial word. The word is *communication.* There has been a life-saving communication among ourselves, with the world around us, and with God.

From the beginning, communication in AA has been no ordinary transmission of helpful ideas and attitudes. It has been unusual and sometimes unique. Because of our kinship in suffering, and because our common means of deliverance are effective for ourselves only when constantly carried to others, our channels of contact have always been charged with *the language of the heart.* And what is that? Let's see if I can communicate to you something of what it means to me.

At once I think of my own doctor, William Duncan Silkworth, and how he ministered to me with the language of the heart during the last shattering years of my alcoholism. Love was his magic, and with it, he accomplished this wonder: he conveyed to the foggy mind of the drunk

that here was a human being who understood, and who cared without limit. He was one who would gladly walk the extra mile with us, and if necessary (as it often was) even the last mile of all. At that time he had already tried to help over twenty thousand drunks, and he had failed with nearly all of them. Only here and there had this dismal experience of futility been brightened by a genuine recovery. People wondered how he could go on, how he could still believe in the possibility of help for chronic alcoholics. Yet he believed with a faith that never faltered. He kept saying, "Someday we'll find the answer."

Obsession Plus Allergy

He had developed some ideas of his own about what ailed drunks: they had an *obsession* to drink, a veritable and a destructive lunacy. Observing that their bodies could no longer tolerate alcohol, he spoke of this as an *allergy*. Their obsession made them drink and their allergy was the guarantee that they would go mad or die as they kept it up. Here, in contemporary terms, was the age-old dilemma of the alcoholic. Total abstinence, he knew, was the only solution. But how to attain that? If only he could understand them more and identify with them better, then his educational message could perhaps reach into those strange blind caverns of the mind where the blind compulsion to drink was entrenched.

So the little doctor who loved drunks worked on, always in hope that the very next case might somehow reveal more of the answer. When I came to him his more recent concepts and tactics had begun to produce slightly improved results. So he was encouraged, and attempted to help me with something of the enthusiasm and hope of a young doctor on his first critical case. He told me what an infernal malady alcoholism is, and why. He made no promises and he did not try to conceal the poor recovery rate. For the first time I saw and felt the full gravity of my problem. I learned, also for the first time, that I was a sick man emotionally and physically. As every AA today knows, this knowledge can be an enormous relief. I no longer needed to consider myself essentially a fool of a weakling.

This new insight, plus the little doctor's account of a few of his good recoveries, brought me a surge of hope. But above all, my confidence rested on the understanding, the interest, and the affection he so freely gave me. I was not alone any more with my problem. He and I could work it through. Despite several discouraging slips, I truly believed this for quite a while. And so did he.

But the hour finally arrived when he knew that I was not going to be one of his exceptions. He would have to begin to walk that last mile with my wife Lois and me. Characteristically he found the courage gently but frankly to tell us the whole truth: neither my nor his nor any other resource he knew could stop my drinking; I would have to be locked up or suffer brain damage or death perhaps within a year.

Language of the Heart

It was a verdict I would not have accepted from any other person. He had spoken to me in the language of the heart, and so I was able to receive the truth he offered me. But it was a terrible and hopeless truth. He spoke in the name of science, which I deeply respected, and by science I seemed condemned. Who else could have driven home this indispensable principle on which recovery depends? I seriously doubt that any

other man alive could have done it.

Today every AA member implants in his new "prospect" just what Dr. Silkworth so powerfully lodged in me. We know that the alcoholic has to "hit bottom"; otherwise not much can happen. Because we are "drunks who understand," we can use that nutcracker term of the obsession-plus-the-allergy as a tool of such power that it can shatter the alcoholic's ego at depth. Only thus can he be convinced that his own unaided resources offer little or no chance for recovery.

Channel of Communication

I was in precisely this state of inner collapse when, in November of 1934, I was visited by Ebby. He was an old friend, an alcoholic, and my sponsor-to-be. Why was it that he could communicate with me in areas that not even Dr. Silkworth could touch?

Well, first of all, I already knew that Ebby was a hopeless case—just like me. Earlier that year I had heard that he, too, was a candidate for the lockup. Yet here he was, sober and free. And his powers of communication now were such that he could convince me in minutes that he really felt he had been released from his drinking compulsion. He represented something very different from a mere jittery ride on the water wagon. And so he brought me a kind of communication and evidence that even Dr. Silkworth could not give. Here was *one drunk talking to another.* Here was hope, indeed.

Ebby told me his story, carefully detailing his drinking experiences of recent years. Thus he drew me still closer to him. I knew beyond doubt that he had lived in that strange and hopeless world where I still lived. This fact established his *identification* with me. At length our channel of communication was wide open and I was ready for his message.

And what was his message? All AA's know what it was: honesty with oneself—leading to a fearless moral inventory of character defects; a revelation of these defects to another human being, the first humble and faltering steps away from isolation and guilt; willingness to face up to those we had harmed, making all possible restitution. A thorough house-cleaning inside and out is necessary before we are ready to devote ourselves in service to others, using the understanding and language of the heart, and seeking no gain nor reward. Then there is that vital attitude of dependence on God, or a "higher power."

None of Ebby's ideas were really new. I'd heard them all before. But coming over his powerful transmission line they were not at all what in other circumstances I would have regarded as conventional cliches for good "church" behavior. They appeared to me as living truths *which might liberate me as they had liberated him.* He could reach at depth.

But in one respect I still backed away. I could not have faith in a power greater than myself, because I could not believe there *was* any God. Ebby sold me his other ideas at once, but not this one. I could not share his faith, as much as I had to admit its very evident result. I had struck an impasse with which thousands of incoming AAs have

since collided.

Mine was exactly the kind of deep-seeded block we so often see today in new AA members who say they are atheistic or agnostic. Their will to disbelieve is so powerful that apparently they prefer a date with the undertaker to an open-minded and experimental quest for God. Happily for me, and for most of my kind who have since come along in AA, the constructive forces brought to bear in our fellowship have nearly always overcome this colossal obstinacy. Beaten into complete defeat by alcohol, confronted by the living proof of release, and surrounded by those who can speak to us from the heart, we have finally surrendered. And then, paradoxically, we have found ourselves in a new dimension, the real world of Spirit and of faith. Enough willingness, enough open-mindedness—and there it is!

A New Freedom

When my own time for open-mindedness and surrender finally came, that new world of Spirit burst upon me in a flash of overwhelming conviction and power. And as a result, freedom from obsession, faith in God, and a consciousness of His presence have remained with me ever since, regardless of subsequent ups and downs. The gift of faith instantaneously became a part of me. My pride had paid a very high price. In despair I had cried out, "Now I am willing to do anything. If there is a God, will He show Himself?" And He did. This was my first conscious contact, my first awakening. I asked from the heart, and I received.

With this illumination came the vision of a possible chain reaction, one alcoholic working with another. I was convinced that I could give to fellow sufferers that which Ebby had given to me, and for months afterwards I tried to carry the message. But nobody sobered up. I was painfully learning *how not to communicate*. A wonderful lesson came out of this experience: No matter how truthful the words of my message, there could be no deep communication if what I said and did was colored by pride, arrogance, intolerance, resentment, imprudence, or desire for personal acclaim—even though I was largely unconscious of these attitudes.

Without realizing it I had fallen pretty heavily into these errors. My spiritual experience had been so sudden, brilliant, and powerful that I had begun to be sure I was destined to fix just about all the drunks in the world. Here was pride. I kept harping on my mystical awakening, and those I was trying to help were uniformly repelled. Here was imprudence. I began to insist that every drunk should have a "bright-light uplift" just about like mine. I ignored the fact that God comes to man in many ways. I had begun in effect to say to my clients, "You must be as I am, believe as I believe, do as I do." Here was the sort of unconscious arrogance that no drunk can stand! I began loudly to point out the sins of my "prospects" (mostly the sins I supposed I didn't have) and the prospects got sore and so did I. When they got drunk, I got mad. And here was hurt pride again.

My new Oxford Group friends (the religious group in which Ebby had made his first, but not final recovery) objected to the idea of alcoholism as an illness, so I quit talking about the allergy-plus-the-obsession idea. I wanted the approval of these new friends, and in trying to be humble and helpful, I was neither. Slowly I learned, as most of us do, that when the ego gets in the way it blocks communication.

I needed another big dose of deflation, and I got it. The realization

dawned on me that for six months I had failed completely. Then Dr. Silkworth gave me this crisp advice: "Quit preaching, quit harping on your spiritual experience. Tell your own story. Then pour into those drunks how medically hopeless alcoholism is. Soften them up enough first. *Then* maybe they will buy what you really have to say. You've got the cart before the horses."

My meeting with Dr. Bob in Akron marked my first successful rapport with another alcoholic. I followed Dr. Silkworth's advice to the letter. Dr. Bob did not need spiritual instruction. He already had more of that than I did. What he did need was the deflation at depth and the understanding that only one drunk can give another. What I needed was the humility of self-forgetfulness and the kinship with another human being of my own kind. I thank God for providing it.

Mutual Need

One of the first insights Dr. Bob and I shared was that all true communication must be founded on mutual need. Never could we talk *down* to anyone, certainly not to a brother alcoholic. We saw that each sponsor would have to humbly admit his own needs as clearly as those of his prospect. Here was the foundation for AA's Twelfth Step to recovery, the Step in which we carry the message.

Our next great adventure in communication was the book, "Alcoholics Anonymous," published in 1939. After four strenuous years we had produced three small groups and less than a hundred recoveries. We knew we could communicate face to face. But it was very slow going. As we prepared the book, we all wondered, "Could the written word 'carry the message'?" Could the book speak the language of the heart to the

drunk who read it? We didn't know; we simply hoped. But now we do know.

"Alcoholics Anonymous" appeared in 1939. At that time, remember, there were one hundred drunks who had recovered through AA. And there were five million alcoholics and their families in America alone who had never heard of Alcoholics Anonymous. There were perhaps another twenty million sufferers in other parts of the world. How were we going to get the good news to even a fraction of all these? There was now a book about AA, but almost nobody outside the fellowship knew about it.

It became apparent that we would have to have the help of press and radio, that we would need communication resources of every kind. Would they be friendly? Would they be able to place a true image of AA before the alcoholic and his family and friends?

The answer turned out to be yes. In the fall of 1939, Elrick Davis, a fine reporter, wrote a series of stories about us in the Cleveland *Plain Dealer*. These articles embodied truly wonderful insight into what AA really is and what it can do, and within a few days *several hundred* alcoholics and their families literally swamped the small AA group in Cleveland with pleas for help. In 1941 Jack Alexander wrote his famous *Saturday Evening Post* feature article on Alcoholics Anony-

mous. And for the first time we saw what nation-wide communication in the language of the heart could mean.

Tremendous Impact

The impact of his article upon the alcoholics of America, upon their families, and upon the general public was tremendous. There was an immediate deluge of calls for information and for help—not hundreds but thousands. We were flabbergasted. It was evident that our recovery message could be transmitted all over the country—if we did our part.

As our fellowship now entered its period of rapid growth, the Traditions of AA gradually took form. The Twelve Traditions communicate our principles of unity as the Twelve Steps communicate our principles of recovery. The Traditions show how an AA member can best relate himself to his group, to other groups, and AA as a whole to the world around us. They show what AA membership is; they reveal AA's experience in matters of authority and money; they guard against compromising alliances, professionalism, and our very natural desires for personal public acclaim. The Twelve Traditions were slowly evolved during an era when large-scale publicity was causing new groups to spring up like popcorn on a hot griddle. Many a power-driven ego ran hog-wild among us in those days, and it was the Traditions which finally brought order, coherence, and effective functioning out of the noisy anarchy which for a time threatened us with collapse.

The Traditions are neither rules, regulations, nor laws. No sanctions or punishments can be invoked for their infraction. Perhaps in no other area of society would these principles succeed. Yet in this fellowship of alcoholics the unenforceable Traditions carry a power greater than that of law. For years now we have seldom seen a serious departure from them. The example of the very few who have persistently ignored them has not caused others to follow suit. We obey our Traditions willingly because of the need for AA survival. We obey them because we ought to and because we want to. Perhaps the secret of their power lies in the fact that these life-giving communications spring out of living experience and are rooted in sacrificial love.

Even in the very earliest days of AA we began to find that the kinship of having suffered severe alcoholism was in itself not enough. We saw that in order to cross certain barriers, our channels of communication had to be broadened and deepened. For example, practically all of AA's first members were what we today call last gasp, or low-bottom, cases. When the mildly-afflicted or high-bottom cases began to turn up they often said, "But we were never jailed. We were never in mental hospitals. We never did those frightful things you fellows talk about. Maybe AA is not for people like us."

New Approach

For years old timers simply could not communicate with such folks. Then out of much experience a new approach was developed. To each new high-bottom member we emphasized the medical view that alcoholism is a fatal and *progressive* malady. We concentrated on the earlier periods in our drinking careers when we had mild cases of alcoholism. We recalled how sure we were that "next time we can control ourselves" when we took a few drinks, and how our drinking was the fault of unfortunate circumstances of the behavior of other people.

Then we took the prospect through the parts of our histories which pro-

ved how insidious and irresistible the progress of the illness is. We showed him how, years before we realized it, we had actually gone much beyond the point of no return so far as our own resources of strength and will were concerned. We kept pointing out how right the doctors are in their assessment of this malady.

Slowly but surely this strategy began to pay off. The low-bottoms began to communicate at depth with the high-bottoms. And the high-bottoms began talking to each other. As soon as any AA locality took in even a small number of high bottom drunks, progress with this class of sufferer became very much faster and easier. It is probable that about half of today's AA membership has been spared that last five, ten, or even fifteen years of unmitigated hell that we low-bottoms know all too well.

In the beginning, it was four whole years before AA brought permanent sobriety to even one alcoholic woman. Like the high-bottoms, the women also said they were different. But as communication was improved, mostly by the women themselves, the picture changed. Today our sister AAs are many thousands strong.

The skid row man said he was different. Even more loudly the socialite (or Park Avenue stumble-bum) said the same. So did the practitioners of the arts and the professions. So did the rich, the poor, the religious, the agnostics, the Indians, the Eskimos, the veterans, and the prisoners. But that was years ago. Nowadays they all talk about how very much alike we alcoholics are when the chips are down.

By 1950 this one big question remained unanswered: Could we communicate overseas? Could AA transcend the barriers of race, language, religion, culture and wars? What about the Norwegians, the Swedes, the Danes and the Finns? What about the Dutch, the Germans, the French, the English, the Scotch and the Israelis? How about the Africans, the Boers, the Aussies, the Latins, the Japanese, the Hindus and the Mohammedans?

So Lois and I wondered a lot as we headed for Europe to see for ourselves that year. The moment we alighted in Norway *we knew that AA could and would go everywhere.* We understood not one word of Norwegian. Scenes and customs alike were new and strange to us. Yet there was a marvelous communication from the first moment. There was an incredible sensation of oneness, of being completely at home. The Norwegians were our people. Norway was our country, too. They felt the same way about us.

As we journeyed from land to land we had the same magnificent adventure in kinship over and over again. In Britain we met with the most wonderful love and understanding. In Ireland we were at one with the Irish. Everywhere it was the same. This was something much greater than people cordially meeting people. This was merely no interesting comparison of mutual experiences and aspirations. This was far more; this was the communication of heart to heart in wonder, in joy, and in everlasting gratitude. Lois and I then knew that AA could circle the globe—and it has.

EMPLOYMEN

With the

BY RAYMOND D. NEWNAM, JR.
COUNSELOR, N. C. EMPLOYMENT SECURITY COMMISSION

ALCOHOLISM is recognized by scientists, doctors, counselors, educators, sociologists and many citizens as an illness and a public health problem. As a public health problem, to which a stigma is still attached, alcoholism becomes the responsibility of the community and its agencies, and they must produce a means of dealing with this illness in an effective and coordinated way.

The North Carolina Employment Security Commission and its local employment offices have an important role to play as agencies of the community in coping with the problem of alcoholism, as persons from all walks of life with job problems seek aid at these offices. The main purpose of the Commission is to help those individuals who come to us find and keep satisfactory jobs. Those of us who work with the Commission are expected to counsel each individual who approaches us for help with this in mind. Certain groups such as the handicapped, recent high school graduates, and elderly persons have special programs provided for them within our organization to enable them to receive more specialized and intensified attention with their more critical problems of employment. How, then, do the problems of employment created by alcoholism fit into the programs of the Employment Security Commission?

We have already stated that alcoholism is an illness. It is nearly always of a chronic nature in that its development and recuperation usually extend over a period of years.

COUNSELING

Alcoholic

An employment counselor discusses his role in helping unemployed alcoholics find satisfactory job placements.

Even after rehabilitation has taken place and the alcoholic no longer has overt problems associated with the active alcoholic, he maintains a severe and dangerous handicap for the rest of his life. This handicap is the inability to drink socially or in other situations without the possibility of again developing the characteristics of the active alcoholic. In this sense, the rehabilitated alcoholic carries a great weight on his shoulders that is continually joustled by society and the weakness of the human body to seek pleasure.

This inability to drink is as real and as severe a handicap in the problem of job adjustment as the loss of a leg or one's hearing. The ability to drink socially is much more important to the alcoholic than to the non-alcoholic. The alcoholic feels a physiological and psychological need for alcohol, and, in addition to that, the ability to drink acquires valuable status for the individual in certain elements of our society. Alcohol for the rehabilitated alcoholic is like candy for the small child who has been told that it will give him a stomach-ache if he eats it. But the pleasure of eating the candy is so great that fear of the stomach-ache is rationalized away.

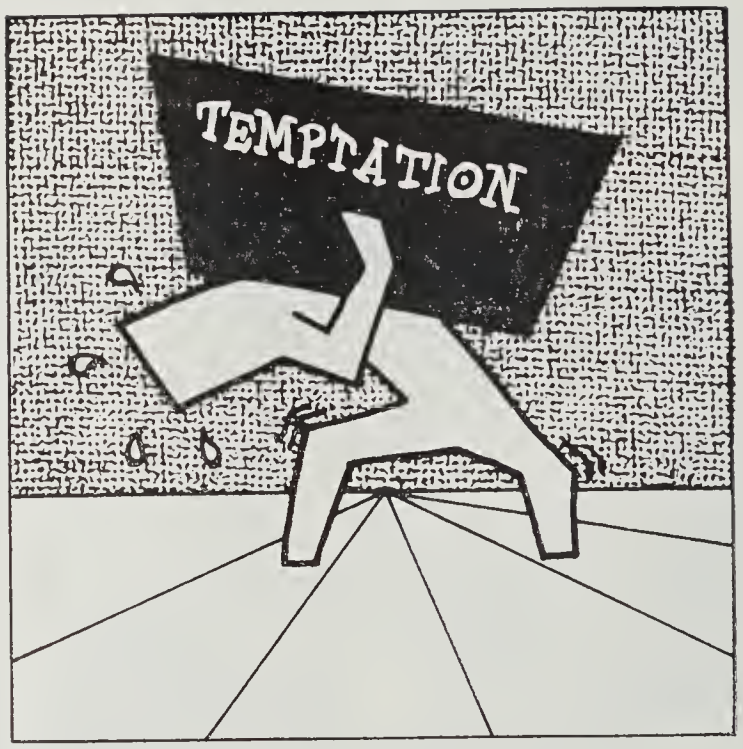
The alcoholic is not only antagonized by the pleasure he might receive from alcohol, but he is continually goaded by psychological, physiological and sociological pressures to break down and yield to the temptation. The questions that naturally come to the mind of the non-alcoho-

lic are: why dosen't the alcoholic have the will power of other adults? Why isn't the blame for his alcoholism placed squarely on him? We will try to answer these questions later.

Let us try to determine the status of the alcoholic seeking the help of the local employment office in finding a job. We have accepted the fact that alcoholism is an illness. We have reason to believe that such an illness leaves a person with a qualified handicap that carries with it a great deal of social stigmatism. The social stigmatism is probably the greatest problem to overcome as far as job placement is concerned. It is my belief that the alcoholic should be treated similar to other handicapped persons.

Probably the greatest responsibility for successful job adjustment by the alcoholic lies with the placement specialist, the vocational counselor and the employer contacted by the local employment office. Oftentimes, job orders for the alcoholic have to be developed or solicited from the employer. This is a job for the placement specialist and the employer visitor. To be able to develop a job for the alcoholic, the person contacting the employer must understand the illness of alcoholism, he should have some idea of the prognosis for successful rehabilitation, and he must have pertinent psychological and physical information about the applicant so that he may impart this information to the employer, so that he, too, will understand the problem. It is easy for an employer to sympathize with and to seek out a job for the man who has lost a leg. It is much more difficult for an employer to sympathize with or accept a diagnosed alcoholic into his organization.

In general, the vocational counselor's reponsibility is to obtain and



interpret information about the alcoholic that is necessary for job placement and counseling purposes. Also, the counselor should assist the alcoholic in choosing a new field of work if it is necessary that he change vocations. In many cases, after an alcoholic has received treatment in an alcoholic rehabilitation center, he finds it necessary or desirable to change his vocation. This may be the result of his own thinking, or on the advice of his doctor, or by friends in Alcoholics Anonymous. In these cases the employment counselor can be of great help. By utilizing his knowledge of the local labor market and job possibilities, and by showing that he understands the problems of the alcoholic, he should be able to effect a good job choice for the applicant.

Probably the most important factor in the successful vocational counseling of the alcoholic is the counselor's understanding of the moral questions involved. It is essential that the counselor be clear in his own mind as to what the ethical problems in alcoholism are, for whether or not the counselor is aware of it, his relationship with the alcoholic will be influenced by what he believes himself concerning these

basic questions.

In order for the counselor to understand the alcoholic, he should examine the etiology of alcoholism. Although scientists and researchers have been unable to determine the exact etiology of alcoholism (it is a complicated illness in that physiology, psychology and society are all involved to varying degrees in each case), they have been able to examine the problem of cause by means of depth psychology.

By use of psychoanalysis and other methods used in depth psychology, researchers have shown that much of man's behavior is not determined by choice but by unconscious forces of his inner self. These modern psychologists imply that all behavior is *caused*—that all behavior is not attributed to free will or change. It is felt that unconscious forces drive man and these forces are controlled by a screen-like device in the personality which directs, screens and inhibits their power to drive man so that his overt behavior is acceptable to his environment and to his fellow man. So, to an extent, a man driven by unconscious forces cannot totally determine his behavior. A person who is self-contained and appears capable of determining his behavior is able to handle the factors of the unconscious forces and to utilize them to his and society's advantage. A compulsive person, however, such as an alcoholic, is driven by these unconscious forces and his behavior and choices are overly acted upon by his environment, early childhood conditioning, heredity and basic drives. The manner in which a person is able to control these unconscious forces determines the degree of compulsive behavior in which he takes part.

Any person who is not totally detached from reality will be able to exert some degree of control over the unconscious forces. In the practice of depth psychology with the alcoholic, it has been determined in many cases that control of the unconscious forces is greatly limited. From all evidence, we find the alcoholic a compulsive person with little ability to judge proper behavior in certain situations. Man himself and society contend that man is capable of controlling himself and that each man is responsible for his actions. Every person—including the alcoholic—bears the responsibility for his behavior. The important thing to remember is that the differences between the alcoholic and the non-alcoholic are factors over which the individual has little or no control.

Even though the employment counselor may feel that he understands the alcoholic and is capable of empathizing with him, there are problems that may arise within the counselor concerning his conceptions and feelings about the alcoholic and his problems. These inner conflicts in the counselor may weaken his ability to work successfully with the alcoholic. At times it is difficult for the counselor to realize that persons who continually seek pleasure from a bottle are sick people. He may find it irritating to discover a short time after locating a job for the alcoholic that he has experienced a slip and has lost another job. After the counselor has seen the same alcoholic experience several more slips and lose several more jobs, he is likely to label this person an "unemployable." Other persons with more subtle emotional problems or physically handicapped persons may have difficulty in holding a job because of certain inadequacies. Very seldom, however, do we term these cases as hopeless.

Probably what is most important in helping an employment counselor arrive at his own working hypothe-

sis is self-examination. He must examine subjectively the factors of alcoholism that are most irritating and difficult for him to accept. Particularly, he must consider his feelings about man's responsibility for his behavior and self-development. He must also examine his own emotional behavior. Intellectual understanding of the factors involved in alcoholism is not sufficient; the counselor must also accept this understanding emotionally. Alcoholics are extremely sensitive people, especially to the behavior of other people. It would not be difficult for the alcoholic to sense emotional aggression of the counselor, should it exist. When the employment counselor reaches the point that he no longer blames the individual for being an alcoholic, then, and only then, is he capable of working effectively with the alcoholic in a counseling situation and speeding up the process of job adjustment and placement.

When the unemployed alcoholic first comes to the employment office, it is very likely that he has a severe financial problem. I have talked with alcoholics who have had such severe financial problems that I do not see how an emotionally stable person could stand similar pressures from his own creditors. The unemployed alcoholic's financial problem has created an emergency which requires immediate attention. If possible, aid of some type should be given at first contact. The alcoholic is not interested in job adjustment, job development or employment counseling. He is interested in an immediate job or money to aid him *now*—when he is in need. If in the initial interview it is found that the applicant has made a suitable job choice or has a skill or profession which he wishes to follow, every effort should be made to refer him to the desired job. If it is felt that further counseling or job development is necessary, it may be wise to refer him to temporary work. If this is not available, the counselor should explore the possibility of unemployment insurance or other financial assistance that might be available in the community. As much help as possible should be extended the alcoholic so that he will be motivated to continue contact with the employment office. After the acute problem of finances is relieved, it is much easier to begin work on the basic problems of job selection, development and adjustment.

The employment counselor has two decisions to make during the first interview: he must decide what type of immediate aid and further services are needed by the individual and what type can be offered by the employment office. These decisions must be made with special reference to known personality characteristics and history of the alcoholic and to the reasons that brought him to the employment office. The counselor must strive to show an understanding of the alcoholic and his problems from the initial contact, so that the alcoholic will be aware that the counselor is genuinely interested in helping him.

There are certain characteristics of the alcoholic which must be taken into account on first contact. The alcoholic is an impulsive person. He does not have the ability to withstand the frustration of impulse. This particular characteristic indicates the advisability of immediate response and action by the employment counselor. The alcoholic depends to a great extent on other people for the evaluation of himself. He has been fussed at, nagged, scorned and punished by his family, by his friends and by his employers. He has, in many cases, been arrested and degraded by society's legal authorities.

His self concept is a reflection of these attitudes. It is possible that the employment agency is his first public contact since beginning his rehabilitation program. It is necessary to treat him as a man with potentital in the working world and to show him the interest and attention that would be shown any other applicant.

Discussing the drinking problem in relation to job possibilities and the problems and frustrations that may be faced in attempting to find a suitable niche for the alcoholic in the working world is sound procedure. This is getting right to the point of the reason the alcoholic is in the employment office. This makes him realize that the counselor is aware of the problems involved and reassures him that you are competent and experienced in dealing with such problems. This may also give him new insight and understanding into employer attitudes, approaches to the employment interview, and some of the responsibilities he is to assume in a search for work.

I feel that we should be willing, at his request, to contact prospective employers for him to tell them of his problems with alcohol, his progress toward rehabilitation and his prognosis. We should not, however, assume all of the responsibility in obtaining work for him. Our main purpose is to give him aid—information, insight and direction. *He* should assume the responsibility, to a great extent, of what he tells the employer of his problem. *He* should do the selling of himself and his skills to the employer. Good job selection by the counselor or placement specialist is important at this point. Not only the requirements of the job but environmental situations should be considered.

The problem of how much information should be given the employer

and who should relate this information has been discussed at great length by employment counselors. Should the alcoholic applicant, when applying for a job, tell his prospective employer that he is an alcoholic? In many cases, the employer is only interested in whether or not he is capable of doing the job. He is not interested in the applicant's personal problems, and in many cases does not want to discuss them. Yet in other cases it is helpful to tell the employer as this may motivate him to create a job in order that he may help the alcoholic. However, it is possible that an employer may become angry if he is not told of the applicant's problem and the alcoholic, should he have been employed, may be fired (it is doubtful, however, in this case, if the alcoholic would have been hired in the first place if his illness had been made known.) No real conclusions have been reached as to what to tell the employer when the alcoholic applies for a job, but an interesting line of thought for the alcoholic in applying for a job is not to volunteer information about his problem, but to answer truthfully each question that he is asked by the employer. Many job applications have a question concerning alcohol

on them. If this is answered truthfully, the employer has every opportunity of questioning the applicant about his problem.

Each Case Different

This brings up another question of ethics concerning the employer and the alcoholic applicant. If we have an order for a job in our files for which the applicant is qualified in skills, ability and experience and feel that he should be referred to this job, should the employer be phoned and told that the applicant you are planning to refer to him is an alcoholic or should this issue be taken up during the interview between the employer and applicant? There is really no definite answer to this problem. Each case should be treated individually, considering both the employer and the applicant before a decision is made. However, I do not feel that in any case the counselor should tell the employer of the alcoholic's problem without first asking the permission of the applicant.

There is one thing that we must always keep in mind and that is that we work for an agency that serves many people, an agency that acts as a link between two factions of the work world. We must, in any case, respect our agency and protect its value to the community by maintaining good relations with both employers and work applicants. Even though we counselors feel dedication to our clients, we must also use logic in our actions in order to maintain good relations with employers.

An employment counselor working along may find that he has a very difficult time without the aid of the placement specialist and employer visitor. Their help is very valuable in developing and soliciting jobs and handling the relations between the employment office and the employer. If the counselor also works with other agencies such as rehabilitation centers, alcohol information centers, Alcoholics Anonymous and other interested community agencies, he will find invaluable aid in solving some of the alcoholic's job problems. Certain types of information such as prognosis, physical effects of alcohol and emotional stability can only be obtained from other agencies.

In counseling the alcoholic, I use essentially the same techniques that I use with other vocational counseling cases. This is a rather modified non-directive technique. In initiating the counseling, I may converse freely with the applicant, discussing known problems involved in the alcoholic's obtaining suitable work. I may ask questions which are apparent and necessary to know before help can be given in obtaining a job. When we reach areas of concern such as difficulties on past jobs, I let the applicant speak freely and ask as many questions as he likes. I may only indicate that I understand what he is talking about. I try never to pass judgment during an interview, and never to allow the alcoholic to become too dependent on me. The responsibility for decisions and the actual acquisition of the job is left up to the alcoholic. I *do* leave the door open to him and insist after he has found a job that he should come back to see me should any problem arise. Together, we may possibly help him keep his job. Actually, I have had little success with alcoholics coming back *before* they lost their jobs; most of the time they lose the job, go on a drinking spree for several days or weeks and *then* return to the employment office.

In the course of my counseling with alcoholics I have talked with many who have been treated at the State Alcoholic Rehabilitation Center at Butner, N. C. The counselors, doctors and workers at this treatment

center have an ability to create such an atmosphere of understanding and respect for each individual alcoholic that when the patient is released after his twenty-eight day stay, he has the feeling that most other persons with whom he'll come in contact will possess the same sort of understanding. But soon—after he has talked to a few individuals who show no understanding—he becomes frustrated and clams up. This "clamming up" becomes most evident when he has failed to obtain a couple of jobs due to his problem with alcohol.

Even though the alcoholic may be rehabilitated or in stages of rehabilitation when he comes to the employment office, this does not prevent him from relating fabricated stories about himself. It is probably an effort on his part to make the counselor see him in a different light from the way he sees himself, and to enhance his possibilities of obtaining work. These fabrications usually center around the alcoholic's past work experience, what he is capable of doing, and many of his past accomplishments. Some alcoholics seem to live in a dream world, even though they know that the counselor knows the true facts about their stories.

Sometimes the alcoholic may seem overly passive and lethargic. It may appear that he does not want work and even after considerable efforts have been made to secure an interview, he may seem reluctant to have it. I have discussed this with several alcoholics and it seems to stem from fear of rejection. One person told me of driving around the block several times before he decided not to attend an interview that had been scheduled for him. He said he did not feel like being turned down again. In many instances, however, you will find the alcoholic persistent, if not so eager, and he will follow any lead or idea that you might give him.

The most satisfactory and successful results that I have had in counseling alcoholics are with those who participate in the program of Alcoholics Anonymous. Not only is an employer more likely to hire an alcoholic who is a member of A. A., but the chances of the alcoholic's slipping seem to be much fewer than those of an alcoholic who does not belong to Alcoholics Anonymous. When talking with an alcoholic, I usually ask if he is an active member of A. A.; if he is not, I encourage him to join.

Business and industry, as an integral part of the community, have a responsibility toward solving the alcoholism problem. Many industries and firms have taken positive steps toward conquering alcoholism by including programs for helping alcoholic employees in their own plants. It would be very helpful if all business concerns would initiate such programs and expand them to include the hiring of alcoholics who have gone successfully through the rehabilitative process. The "yes" answer to the question on the job application that asks "Have you had problems with alcoholism?" should not mean an automatic rejection. It should mean "Yes, we'll consider you for employment here if you will consider entering our special program for rehabilitation of alcoholics should you be hired."

The alcoholic is an individual with a special problem and because of that, he requires special consideration. In order for us to work successfully with him, we must recognize his problem with alcohol as an illness and have a special understanding of his behavior. To help solve the alcoholic's job problem, we must take into consideration his individual abilities and assets as well as his personal problems.

WHAT DOES IT COST to be an ALCOHOLIC?

BY E. HOLT BABBITT

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The dollars add up rapidly when Joe's on a bender.

DR. H. Mac Vandiviere writing in the March-April, 1961 issue of *Inventory* said ". . . It is, therefore, apparent that alcoholism is not a simple disease. It is multiphasic in etiology (or cause); it is developmental, mental, physiologic and biochemical; and it is multiphasic in its signs, symptoms, and impact on the family and society . . ."

One multiphasic impact receiving little emphasis in discussions of alcoholism is the financial involvement of the individual alcoholic. Most references to economic factors concerned with alcoholism mention the direct cost to industry, the amount spent for education of the public, treatment and research by the various governmental agencies and voluntary programs, and the overall estimated cost to society. Few words have been written concerning what it costs an *individual* to drink excessively. This particular aspect has been neglected or deemphasized in assessing economic, emotional and physiological damage to the alcoholic. When an alcoholic takes that first drink, how much does it really cost him?

A study was recently conducted in two groups of patients at a treatment center for alcoholics in the Midwest which indicates that there may be a correlation between the severity of the alcoholic's drinking problem and how free spending he is when drinking.

Nine major categories of spending in which the alcoholic would be involved during the course of his progressive illness were set up and defined by the same counselor who interpreted the findings. The indices for measuring the financial involvement of the individual alcoholic were applied in the regular schedule of group sessions at the treatment center. The counselor interpreted the indices to the patients and then asked the two groups to provide information relative to the nine categories for a twelve-month period prior to their admission. In some cases the previous calendar year was used.

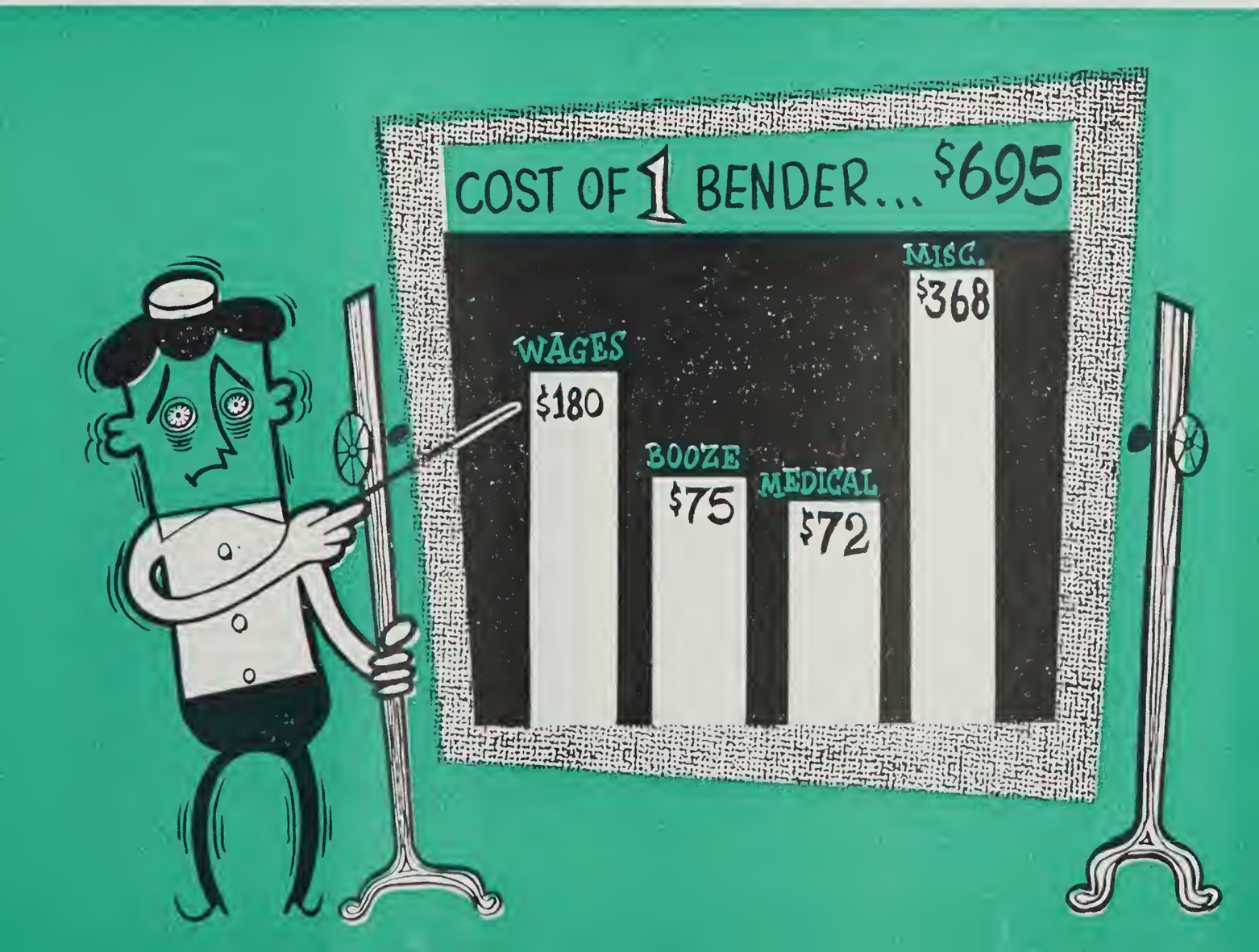
The indices of measurement have not been put to a real test since they have only been used with two groups of patients in one treatment center, and should, therefore, merely be regarded as a guide for determining the seriousness of financial involvement. Psychiatric evaluation, if necessary, psychological testing, physical examination, counseling and other criteria should be utilized in total evaluation of the drinking problem.

The nine categories of spending used in the study as indices of financial involvement follow:

1. *Direct Cost of Alcoholic Beverages.* This category includes beer, wine, whiskey and non-beverage products, too, if applicable. The cost of chasers or mixes, provided these were used, and money spent by others on drinks for the alcoholic individual are also included. (Although the categories are not listed in any particular rank order, this one unquestionably deserves billing as the top ranking expenditure for an alcoholic.)

2. *Loss of Wages.* This category includes days and hours off from work which directly or indirectly resulted from drinking. Unseen here by the casual observer and perhaps the alcoholic, too, is the loss of income from being out of work and the time between jobs. Sometimes a problem drinker may also take a pay cut when going back to work.

3. *Court Fines and Costs.* Bail and bond fees, attorney fees for court appearances, non-support costs, and fines for driving when intoxicated, public drunkenness, and assault and battery fall under this category which can also be broken down into



a sub-category of factors associated with a broken marriage. The latter includes attorney fees for one or both parties for court costs, the expense of filing for divorce or separation, and the eventual payment of alimony or support money. Following the final action, if it does occur, a property settlement may be involved, along with previous bills, plus the ensuing expense of separate living quarters.

4. *Medical Care Costs.* Hospitalization following a bender, medications, the physician's visit to the home to treat the alcoholic in the withdrawal period, visits to the doctor's office, and emergency and long-term treatment for accidents and illnesses incurred while drinking are the cost factors of this category.

5. *Loss of Home and Furnishings or Place of Business.* This category, if the losses do occur during the progression of alcoholism, is very costly and can hike the alcoholic's expenditures way out of proportion. One alcoholic, in his prime working days, lost the management of an exclusive men's shop because of his drinking. As his illness worsened over the years, he went from job to job, city to city, finally ending up clerking in another men's store. When last heard from, he had lost that job, too, and had settled for spot jobs. True, he didn't own the first haberdashery, but he had an excellent earning potential before drinking took precedence over his job.

6. *Accident Expenses.* Under this category come insurance costs (including financial liability), car repairs, medical expenses for injuries to oneself and others, and destruction of personal and public property. A lawsuit could rapidly increase the total of related expenses.

7. *Miscellaneous Expenses.* Some odd and assorted expenses are included in this category. To name a few—taxi fares, long distance telephone calls, extravagant buying, lavish dining and buying drinks "for the house." Many other sundry expenses could be included.

8. *Loss or Sale of Personal Belongings.* This category includes clothing, watches, wallets, pen and pencil sets, cigarette lighters, cameras, and radio or television sets. These items may have been lost through negligence and carelessness while drinking or they may have been sold outright for further purchase of liquor.

9. *Sale of Other Items.* Included in this category are automobiles, work tools, appliances and visits to pawn shops. Overlapping with category 8 could occur here, but, nevertheless, the categories are listed separately.

10. *Other.* This category was set up as a catchall for expenditures not explained elsewhere.

Allowance For Alibis

Allowance has been made for the complex system of alibis an alcoholic uses and believes in. Open-ended questionnaries sometimes leave a few lines at the conclusion for items not listed specifically in structured questions. Category ten was provided just in case the alibing permitted omission of certain expenditures.

It's reasonable to assume an alcoholic would try to rationalize his way out of some expenses incurred. For instance, he could claim no loss of wages from drinking because he was unemployed during the period involved. But why was he unemployed? He might claim that he spent no money for whiskey because he was in prison. But what led to his imprisonment?

Correlating the total expenditures compiled by any number of alcoholics with non-alcoholics would be of little value. Many non-alcoholics have a high liquor bill but, in general, it could be said that the ex-

penditures of alcoholics would exceed those of non-alcoholics in most of the categories used due to the frequency and intensity of their drinking bouts and deeper financial involvements.

Now come the appalling figures. The collective estimate, even though representing only a portion of alcoholics seen in one treatment center for one year, is staggering and serves as a true "eye opener" of the enormity of the problem. Based on the nine major categories of spending, one group of males averaged $1,000 per man for the twelve months preceding admission. Another group totalled $32,000 for a two year period. If the pattern prevailed for the former group, a total of $50,000 would have accumulated over a five year period. By the time many chronic alcoholics are seen in a clinic or affiliate with Alcoholics Anonymous, it is apparent that alcoholism and economic deterioration have progressed hand in hand over the years.

The expenses of a person in the advanced stages of alcoholism will be most dramatic when, after a period of sobriety, he suffers a relapse and goes on a bender. Expenses in some categories are automatic and many alcoholics stand a good chance of rating in the minus column under all nine major categories.

The plateau or daily drinker deserves mention although his drinking pattern is less explosive than that of the chronic and periodic drinker. An alcoholic drinking a pint or more a day, day after day, will rapidly accumulate a bar bill approaching an awesome total.

Variations of individual totals, however, are innumerable. To illustrate this point and some of the expenses that could be incurred on a drinking spree, let's take a look at a hypothetical alcoholic's expense account while he is on a bender.

Joe is an average guy in his late forties. After fourteen months of sobriety, he goes on a bender that lasts over a week. He starts drinking after work on a Friday night and reaches his saturation point eight tortuous days and nights later. Let's take a look at Joe's expense account for this period:

The direct cost of alcoholic beverages which Joe consumed was $75.

As a good shoe salesman, Joe usually brought home $90 per week. He missed one week of work while on the bender and another recuperating from his drinking spree. Hence, Joe's loss of wages for the two weeks was $180.

So far, Joe's bender has cost him $255.

Fortunately, Joe's court fines and costs were not too expensive although he was in no shape to pay them. He received the minimum fine of $12 for two overtime parking tickets.

Joe has now spent $267.

At the end of the spree, Joe went to a hospital where he remained four days at a rate of $18 per day for a total cost of $72. Even though his insurance paid the bill, it's still accountable.

Joe's bender has now amounted to $339.

Joe incurred no losses pertaining to home and furnishings or place of business and had no accident expenses, but his miscellaneous expenses amounted to $60.

Joe's expense account has jumped to $399.

Joe's wife gave him an $80 watch when he celebrated one year of continuous sobriety. He pawned the watch during the bender and lost the pawn ticket. He also lost his wallet with $25 in it, bringing the cost of loss of personal belongings to $105.

Joe's accumulative expenses have now amounted to $504.

Shortly before his spree ended, the finance company repossessed the television set on which Joe had already paid $125.

Joe is now $629 in the red.

Any item which was lost, broken or destroyed will probably be replaced eventually. And this will, of course, involve additional expense. Sooner or later Joe will probably buy a new watch, but this one won't be nearly as nice as the one he pawned—he'll pay about $19.98 for it, maybe. He is an avid baseball fan and loves to watch his favorite team in action on television. So, of course, there's the matter of a new television set, but this time Joe will probably settle for a $40 used model. Including $6 for cleaning the clothes he soiled, another $65.98 must be added to the $629 he has already spent.

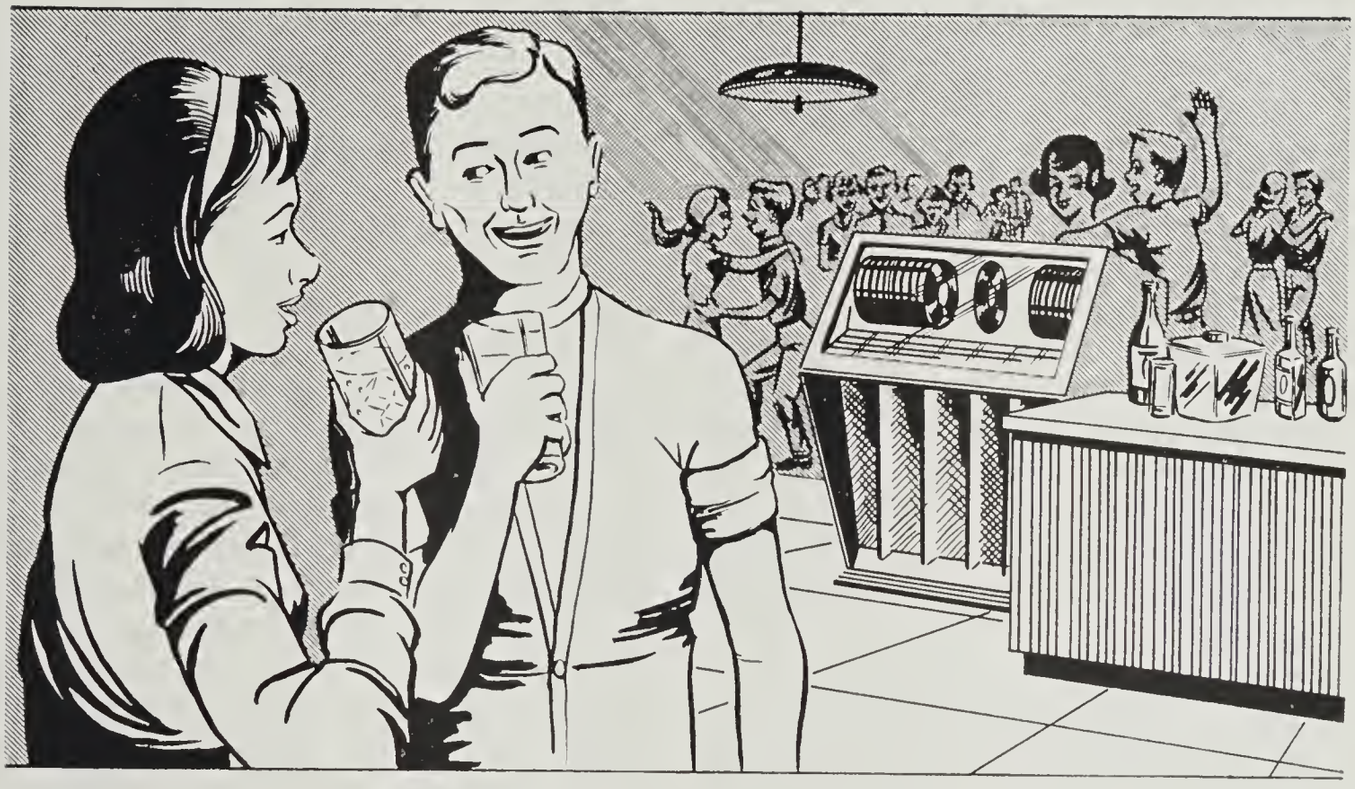
The grand total for Joe's bender is $694.98—but we'll round it off at $695.

Figuring fifteen days of being out of commission and non-productive (eight days for drinking and seven for recuperation), this bender cost Joe $46.33 per day. He spent just over half of one week's pay during each day of his spree. Sure, he got his job back this time, but in the course of breaking his stretch of sobriety, Joe touched on seven of the nine major categories of spending.

Joe could rationalize his costly bender by saying that even though he had slipped he had remained sober for fourteen months. However, the slip was a monetary undoing. The progress he had made on his family budget and monthly payments was wiped out in two weeks. When averaged for fourteen months, Joe's bender amounted to $49.64 per month. If, in his quest for sobriety, Joe just couldn't remain sober and went on a drinking spree every fourteen months for 5.8 years (allowing for five sprees spaced fourteen months apart), he would spend a total of $3,475.

The financial involvement and economic chaos an alcoholic experiences is very difficult to measure and is, of course, relative and varies with each individual alcoholic. It can be said, however, that it costs money to drink whether the individual's drinking pattern is daily, weekend, or periodic. Dollars and cents add up rapidly for the alcoholic who has not taken a few moments to figure out how much one drink may cost him. Finance companies, loan sharks, pawn shops, banks and credit unions in addition to increasing dependence on relatives, friends, churches and agencies are some of the sources that will inevitably be relied upon for assistance in the financial crises of alcoholics.

As alcoholism can be prevented, so can preventive steps be taken to avoid what Joe went through. If individuals who suspect that they are on the road to alcoholism would seek help early, their ultimate cash outlay for treatment would be far less than what a bender cost our hypothetical Joe or thousands like him. And, in all probability, they could avoid costly $695 slips.



The Problem of Teen-age Drinking

BY HERMAN E. KRIMMEL

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Attitudes created as a result of education play a vital role in the teen-ager's approach to drinking.

DURING recent years there has been growing alarm about drinking among adolescents. One sometimes gets the impression that many teen-age parties are drunken brawls, that sharp rises in delinquency and unwed motherhood can be traced to the guzzling of alcohol, and that high school students are forever sneaking off to rest rooms for a "quickie."

The evidence does not support these notions despite the fact that teen-age drinking is probably increasing. Michigan sociologist Christopher Sower, for example, found that one-third of 2,247 junior and senior high school students drank occasionally. In Nassau County, New York, it was discovered that 70% of 1,000 youngsters questioned had sampled alcoholic beverages by the time they were fourteen and this increased to 90% at the age of sixteen. Similar conditions have been found elsewhere.

The explosive but futile reactions to these data have tended to blind parents, teachers and law enforcement officials to the fact that while teen-agers are drinking in ever increasing numbers, the consequences may not be as disastrous as the statistics imply. A lot of teen-agers may drink, but most of them don't drink much.

One fact is of paramount importance. The drinking of alcoholic bever-

ages is an established custom in our society and indulged in by at least two-thirds of the adult population. Children growing up in this society are likely to accept the pattern. Obviously, there are dangers involved in drinking and if one drinks, one may get into trouble. There are at least as many dangers in driving an automobile, and if one drives, the potential for a serious accident is always present. It is not likely that either driving or drinking will be outlawed, although we can continue to hope there will be less mixing of the two.

Education—Not Prohibition

Sound education rather than prohibition is the goal. In schools and homes we teach teen-agers all we know about the hazards of misusing the privilege of driving, and it would appear that the same approach is valid for drinking. This does not mean the use of "scare" techniques which are frequently self-defeating. There is little point, for example, in the warning that anyone who drinks can become an alcoholic. It is true, of course, but it is equally true that most people who drink do *not* become alcoholics. To return to our analogy, it is indisputable that anyone who drives a car can be killed, but that does not justify the elimination of automobiles from modern life.

The attitudes that are created as the result of education will play a vital role in the teen-ager's approach to drinking. It makes a difference whether the boy approaching maturity thinks he has to drink "to be a man", or if he can view drinking as a custom he can accept or reject in moderation according to his own choice. There is a difference between the college girl who drinks because it is a deliciously wicked thing to do and the one who can accept a cocktail as the adult she is striving to be. And above all, education in this area is *never* education to drink, but education about alcohol with the decision to drink or not to drink always a matter for individual judgment.

We are inclined to be alarmed about teen-age drinking in the wrong contexts. Too many "scare" headlines, for example, relate drinking to juvenile delinquency, but no cause and effect relationship has ever been established. Certainly many, but not all, delinquents drink. These are boys and girls, however, with tragic emotional difficulties and their problems did not originate in liquor. There is every reason to believe that they drink because they are delinquent. They are not delinquent because they drink.

Teen-age drinking merits attention, but not the all too usual viewing with alarm and anguished wringing of adult hands. These futile energies should be redirected into efforts to provide sound information free from unnecessary concern and prejudice.

Whether we like it or not, children are growing up in a drinking culture. Approximately 70 percent of the adults in the United States drink alcoholic beverages. Some may have only a few drinks during a month or a year, most are moderate social drinkers, and about 6 percent are alcoholics. This majority, of course, has its opposite in the large and frequently articulate minority of 30 percent who are abstainers.

Important Decision

As young people approach or reach adulthood, they have to decide whether or not they will drink. Obviously, this decision is not reached in a sudden moment of revelation. Drinking is a custom which one shuns or accepts over a long period of time, but it is an area still charged

with controversy, so that the pressures and strains from both sides can be disturbing.

There is clearly an imperative need for sound alcohol education. Every state in the union requires some instruction about alcohol in the curricula of its schools, but the quality ranges from superior in a few school systems to mediocrity in many and to a level of shocking inferiority in some.

Anyone who discusses the problems of alcohol with groups of high school students must be impressed by their sharp interest. This interest merits the best the schools can offer. The students have a right to hear an impartial presentation of the available knowledge about alcohol and alcoholism. It is essential, for example, that they learn that one of every fifteen drinkers becomes an alcoholic, but it is equally essential for them to know that the other fourteen drink socially without impairing their normal and competent functioning.

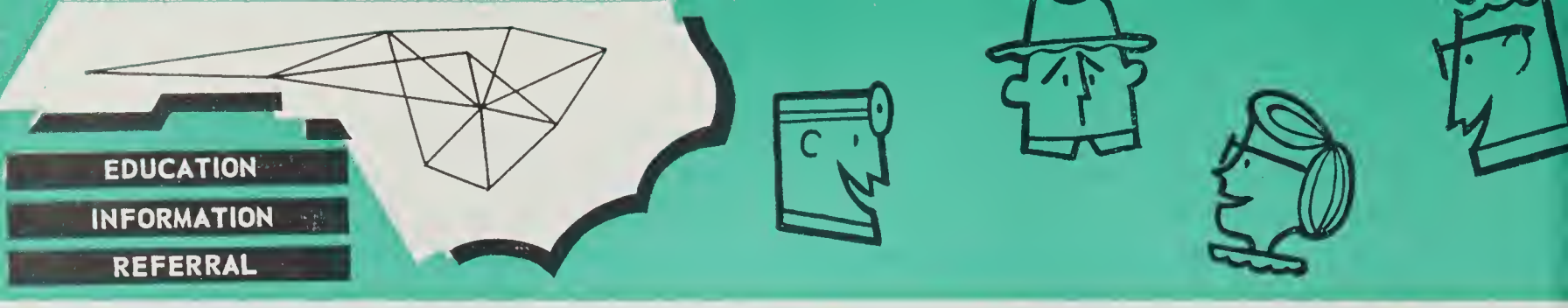
Certainly, children should know that alcoholism is an illness and not a moral dereliction. They should know that only a small minority—not more than 5 to 7 percent—ever sink to skid row. The rest, except for their compulsive drinking, are no different from the friends and neighbors of the students and their families.

Children should be taught what alcohol is. It is neither the root of all evil as some extremists believe, nor is it ever the solution to basic problems as many problem drinkers so mistakenly and tragically think. It is certainly not a poison in the sense that arsenic is, for example, because it does not kill by direct action on the tissues, although reckless and excessive intake may fatally derange the metabolism. It is a drug in the sense that it is essentially a sedative and has anesthetic qualities. On the other hand, it is not a drug in the same category as morphine and heroin because it does not automatically create a body tolerance that demands continuing and increasing doses. Alcohol is also a food if caloric content alone qualifies it, because it is loaded with calories. However, it has no other food value. It has no minerals, vitamins, carbohydrates, proteins or related essentials for physical well-being.

Facts alone are not enough. Some parents and teachers seem to believe that, if given sufficient data, students will list the advantages and disadvantages on debit or credit sides of a ledger and decide to drink or not to drink in accordance with the balance. Actually, adolescents start to drink, if they start at all, during the gradual, almost imperceptible, process of testing experiences at home, among their friends, at celebrations. The facts, therefore, are useful only in relation to the climate in which they are learned. Healthy attitudes are vitally important at home and in school. Unfortunately, as in other controversial areas such as sex education, few teachers and parents are equipped to communicate in a positive manner.

Effective alcohol education must be realistic. The fear technique based on "the threat of alcohol" is popular, but it has many disadvantages. For one thing, it doesn't work. Most students know that death and disease are not inseparable companions of alcohol. The possibility that they might, in the distant future, become alcoholics or the victims of liver cirrhosis because they take a drink has little meaning. Education restricted to well-meaning advice is futile.

This article, originally published in the Cleveland News, a publication of the Cleveland Center on Alcoholism, is reprinted by permission.



Currently In North Carolina there are twelve

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—
Citizens' Committee on Alcoholism
Rev. Robert L. Torrence, Chairman
50 College Street, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary — Phone: 942-7253

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellerman, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
211 Snow Building
Mrs. Olga Davis, Executive Director — Phone: 682-5227

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade— Phone: BRoadway 4-1295
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
Rev. Edward Laffman, Director

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
119 N. Scales St., P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public libarary to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

VOL. 11, NO. 3 SEPT.-OCT., 1961

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

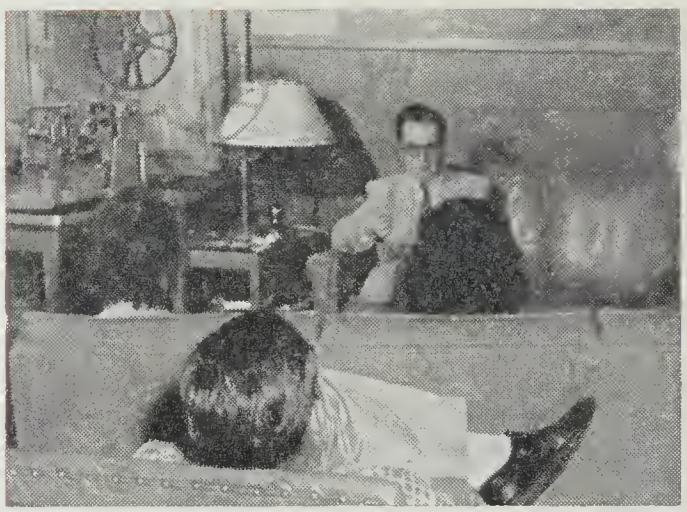
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a through medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

INVENTORY

VOLUME 11 NUMBER 3

SEPTEMBER-OCTOBER, 1961

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: A new state-wide program aimed at reducing the rising tide of readmissions to North Carolina mental hospitals is being initiated by the North Carolina Hospitals Board of Control. The first step in the program will go into effect in September with the opening of two out-patient clinics at Dorothea Dix and Rex hospitals in Raleigh. The Dorothea Dix clinic will accept any of the hospital's former patients and discharged alcoholic patients from Wake, Durham, Johnston and Harnett counties. It will be open Tuesday through Friday from 1:30 p.m. to 4:00 p.m. The clinic at Rex will not be open to alcoholic patients but will accept former mental patients from private hospitals, depending upon the needs of the patients, as well as former state hospital patients. Clinic hours will be from 8:30 a.m. to 12:00 noon on Monday and Friday. The state-wide program will eventually include additional clinics throughout the state for the aftercare of former mental patients, vocational rehabilitation units in state hospitals, and rehabilitation centers to help patients in their adjustment to a normal life.

ONTARIO, CANADA: Fifty doctors and dentists and their families from the United States and Canada attended the fourteenth annual meeting of "International Doctors in A. A." in Toronto, Ontario, Canada August 11-13, 1961. Papers and discussions by members and scientific presentations by guests comprised the program. The 1962 meeting will be held in Moline, Illinois.

LAURINBURG, N .C.: A group of interested citizens in Laurinburg recently formed North Carolina's 13th local program on alcoholism. Dr. Norbert L. Kelly, associate director of the NCARP, and educational director George A. Adams assisted with the pre-organizational planning of the program. Recently, the group adopted a constitution and by-laws and elected officers. James L. Sutherland, Jr. was named president of the organization, known as the Scotland County Citizens' Council on Alcoholism.

N.A.A.A.P. JOINS INTERNATIONAL BUREAU: The North American Association of Alcoholism Programs has become a member of the International Bureau Against Alcoholism, according to Dr. John R. Philip, NAAAP president. Headquarters for the International Bureau are located in Lausanne, Switzerland.

BUTNER, N. C.: On Sunday, September 17, the North Carolina Alcoholic Rehabilitation Center at Butner played host at a reunion of former patients who were at the Center during 1960 and 1961. Highlight of the afternoon's activities was the showing of a new film, entitled "For Those Who Drink," to patients and their families. A discussion led by staff members of the Center followed the showing of the film. Around 150 former patients and family members attended.

INSTANT BEER: Union Carbide Corporation has announced that it has discovered a process which will provide "instant" non-alcoholic beer for those who like the taste but not the effect of the conventional brew. The "instant" beer does not require aging and the non-alcoholic product looks, tastes, smells and even foams like the real thing but contains only one-hundredth of a percent of alcohol.

GRANT-IN-AID: The Scientific Advisory Committee of the Licensed Beverage Industries, Inc. has announced a new grant-in-aid program through which small research grants may be arranged for competent scientists working in the field of alcoholism and related subjects. The grants are expected to range between $2,000 and $10,000 and run for one year. A total of $500,000 will be available over a five-year period. Grants will be awarded to qualified researchers, including young scientists in the biological and behavioral sciences who wish to make preliminary or pilot studies for the purpose of raising or clarifying promising hypotheses.

STARTLING STATISTICS: Much is said about people who drink and drive but you hear very little about the drinking pedestrian who steps in front of an automobile and gets killed. Statistics show that one out of every four adult pedestrians killed in traffic accidents in the United States had been drinking. The North Carolina Department of Motor Vehicles says alcohol has no place in any phase of traffic. It makes little difference if you are killed while driving or killed as you walk across a street; you are just as dead either way.

RALEIGH, N. C.: During the course of the Fiscal year extending from June, 1960 to June, 1961, as part of its public information and educational program, the North Carolina Alcoholic Rehabilitation Program distributed an estimated 152,625 pieces of literature upon request to PTA groups, religious and civic organizations, AA groups and individual members of AA, school children and teachers, and other interested individuals and organizations. The number was in addition to approximately 112,000 copies of **Inventory** which were distributed upon request to persons all over the world. The seventeen films on alcohol and alcoholism which the NCARP has placed in the film library of the State Board of Health have been shown 768 times to an audience estimated at 38,400 persons. **Alcohol and the Human Body** and **Alcoholism** are the two most popular films as to number of showings. In addition, the NCARP distributed 63 radio spot announcements to 154 radio stations throughout North Carolina. These services are only a part of the NCARP's educational program which also includes speaking engagements, displays and exhibits, a book loan service and consultant service to local communities for the establishment of alcoholism programs.

The Tuberculous Alcoholic

May I request placement on your mailing list for *Inventory?* If possible, the back issues for 1961 would be greatly appreciated.

We are in the process of initiating treatment methods for the tuberculous alcoholic patient and I feel that the content of *Inventory* will be most valuable to us as a guide for the adaptation of a fitting philosophy in our attitudes.

Congratulations on the excellent contribution you are making to the field of alcoholism.

Ron Fagan
Special Consultant on
Medical-Social Problems
Firland Sanatorium
Seattle, Washington

Inventory's Anniversary

Congratulations on the anniversary of *Inventory*. Your publication is much appreciated and I trust my name will long remain on your mailing list.

I like the size and format and the articles are most interesting and useful and reflect the care with which they are chosen and the dedication of the authors.

S. E. Armstrong
Superintendent,
Ontario School For the Blind
Brantford, Ontario

Help For Family

Please add my name to your mailing list. My daughter-in-law saw a copy of your magazine at her doctor's office. I hope it will help with our problem.

Anonymous
Burgaw, N. C.

Nurse Writes

I am conducting a course for the advanced Medical Specialist. Your publication, *Inventory,* would be a valuable reference for our teaching. Kindly place our name on your mailing list for the above publication.

Leda E. Jelinek
Major, Army Nurse Corps
Director
Fort Bragg, N. C.

Fine Magazine

I have read several copies of your fine magazine, *Inventory,* and would like very much to be placed on your mailing list.

North Carolina seems to be really moving on this serious problem.

Mary B. Hasenfus
Dahlgren, Virginia

Wealth of Material

I have recently read an issue of your magazine *Inventory* and am very impressed with the wealth of material which it contains. This information would be invaluable to a minister. As well you know, we work with alcoholics a great deal. Often, information such as appears in your magazine would help greatly in dealing with these people. I would appreciate your adding my name to your mailing list. Receiving *Inventory* would be of great assistance to me.

Reverend George L. Painter
Mouth of Wilson, Virginia

VOL. 11, NO. 3 INVENTORY SEPTEMBER-OCTOBER, 1961

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

A surprisingly large number of alcoholics are being rehabilitated by a variety of therapists using dozens of methods, even though there is no common agreement on the etiology of alcoholism.

IDENTIFICATION of ALCOHOLISM

BY RALPH L. DANIEL, M.S.W.
EXECUTIVE DIRECTOR
MICHIGAN STATE BOARD OF ALCOHOLISM

OUT of the many diverse theories on alcoholism, and the heated disagreements on causes and treatments, is coming a surprising number of sober alcoholics. Thousands of alcoholics are getting help from hundreds of therapists using dozens of methods. There has been no scientific study of the relative effectiveness of the many methods being used; but the successes claimed by methods, ranging from the psychiatrist's couch to casting out demons, is an amazing thing at a time when there is no common agreement on the etiology of alcoholism. The fact that help for the alcoholic is coming from such a variety of methods raises the question of the importance of treatment methods, and suggests that there may be a common underlying factor that is camouflaged by the pet theories of the therapists.

It can be noted in passing that alcohol has been used by man at least as long as man has been recording his history. It is probable that the methods used to treat people with alcohol related problems have a history as long as man's acquaintance with alcohol. Earlier methods centered around one of two general ideas. The "offender" was either punished, or hidden and pampered. It cannot be said that these methods have been abandoned, nor can it be said that they were entirely ineffective. There is common agreement

that the modern "treatments" of "acceptence but no condonation; protection but with encouragement toward as much independence as possible; a struggle to break through the complicated and self-induced sense of isolation, with the recapture of lost values; and improvement of physical condition" are more enlightened and more effective than those methods used prior to the last quarter century.

The most promising avenue to a limitation of the problem lies in a look at the alcoholic and, more specifically, at the methods that help him and the theories suggested by those methods.

Variety of Viewpoints

In the United States, we are paying "lip service" to the idea, "Alcoholism is a disease," but we have not yet truly grasped the meaning of the idea. The resentment and rejection of the alcoholic that is prevalent today may well stem from the frustration of an inability to help or to understand him. Such rejections cannot easily be uprooted. Even now, when the general public is in the no-mans-land between accepting the words and accepting the idea, some of the experts are saying that alcoholism is not a disease entity but a symptom of some underlying cause or causes. Some groups openly reject the disease ideas altogether.

There is no voice in the question that speaks from a longer history than do the temperance groups. Long before there was a scientific approach to alcoholism, or any substantial group of sober alcoholics, these "Dry" groups looked at the results of execessive drinking as social and personal problems resulting from the use of alcohol. They saw in alcohol the cause of all drinking problems. These groups have long fought for voluntary and compulsory abstinence and they have fought against the liquor interests. The idea that alcoholism is a disease is not easily reconciled with the traditional idea that the "curse" was in the bottle. Some of the "Dry" groups have recognized the disease to the extent that they say, in essence,—"Alcohol problems are like diseases and alcohol is the germ." Some "Dry" groups fully accept the disease idea and see in alcohol a contributing factor. Others reject it completely.

The liquor interests see something quite different in the "disease concept." They see themselves as manufacturing and selling a product that has been made a legal commodity by popular vote. Like all industries in a capitalistic country, they recognize growth, expansion, increased consumption and increased profits as criteria of success. They recognize that the misuse of their product might reflect on their sales. They feel the need to minimize alcohol related problems and to point to causes other than alcohol. If alcoholism were not named after their product, they would undoubtedly throw their weight behind the disease idea. Having a disease named for a legal product is slander. The idea that alcoholism is a disease presents dilemma for the "Wets."

Both the "Wets" and the "Drys" have their points. If alcoholism is a disease in itself, it could be eliminated provided alcohol could be eliminated. If it is a symptom, then the symptom is worse that the cause and the individual would be better off if he could be denied this symptom. On the other hand, if the problem lies in the drinker, instead of the drink, it is misleading and unfair to name the malady after a legal product.

If one recognizes a broad definition of the word "sick" and accepts the idea that the body may be sick,

or the mind may be sick, or the spirit may be sick, then there will be no logical objection to limiting the problem by saying, "Alcoholics are sick people." This may be a broad limitation but it makes room for both the "disease idea" and the "symptom idea."

The day will come when it can be clearly demonstrated what made this person sick and what will make him well. That day will not be hastened by pretending to know these things now. That day will not be hastened by argument on the many

ideas. The best bet is to recognize present ignorance, and look at each new idea as a potential addition to a growing body of knowledge that will some time answer the questions. It may be folly to attempt to identify or limit the problem now. It can be stated now that, "With present available knowledge, alcoholism is an indefinable and illimitable human problem."

Science has made real progress with a very simple plan known as "theories." The scientist uses his imagination to say "A" could be caused by "B". If "B" causes "A" then "A" could be prevented by avoiding "B", or "A" could be treated by eliminating "B" using plan "C". Cancer (A) may be caused by certain things, (B). If this is true, then cancer could be prevented by avoiding these things, or it could be treated by (C) a method of eliminating these things. The scientist guesses at the unknown, then he tests his guess. He doesn't argue his theory, he tests. He recognizes that his theory may be wrong. He may even try to prove that it is wrong. He is not satisfied if his theory proves true part of the time. This does not mean that the theory is useless or that it is not a good theory. A theory that proves true in some cases can be valuable in those cases where it works, and if no serious results are found where it does not work, it is a good theory. The percentage of cases where a theory works may be a good criterion of the real value of that theory.

There are many theories about alcoholism. Most of them work part of the time. None of them work all of the time. Unlike the scientist's need to question and test his theory, in alcoholism there seems to be a need to argue theories. Many theorists are criticizing the theories of others. This may satisfy personal needs, to prove one is right, but it isn't helping alcoholics. If we are to limit the problem, the need now is to explore definitions and theories, and to test them for validity.

1. *"Alcoholism is a chronic and progressive illness characterized by an excessive and uncontrolled drinking of alcoholic beverages."* This definition comes from the Michigan law that established the State Board of Alcoholism. The words "characterized by" makes this definition a broad definition. The Legislature would have limited the definition considerably if they had used the words "caused by" or "resulting in." One cannot disagree with this definition because there is no doubt that alcoholism and excessive and uncontrolled drinking go together. This definition offers opportunities for more specific definitions but it does not suggest a treatment. It cannot be tested. The Michigan law implies that alcoholism is an undefined chronic and progressive illness with recognizable symptoms.

2. *Alcoholism is a type of insanity or a spiritual illness.* This definition is derived from the Twelve Steps of Alcoholics Annonymous by this author and has no expressed A.A. support. The second step of the A.A. Twelve Steps is, "(We) came to believe that a Power greater than ourselves could restore us to sanity." If the goal is a restoration to sanity, it seems obvious that the successful A.A. member felt that he had lost his sanity or had been insane. This part of the definition will be more readily accepted if one realizes that "sanity" and "insanity" are not clear cut differences, like "male" and "female," but rather opposite ends of a scale, like "hot" and "cold", with varying degrees between. "Spiritual" is interpreted here as a relationship between man and a superior Power which the A.A.'s call "God, as we understand Him." The "Spiritual Illness" is implied from the fact that the Twelve Steps make frequent reference to God, and it is obvious that the A.A. approach is one of spiritual recovery.

Mr. Daniel is the author of numerous articles and is a fairly steady contributor to Inventory. This article, originally published in the Michigan Alcoholism Review, is one of a series prepared by members of the Michigan State Board of Alcoholism, the staff, and Michigan people who have contributed to the development of Michigan's alcoholism program. The Board plans to compile the articles in a single publication at a later date. Several of the author's more popular articles which have been published in Inventory include "Babes in the Woods", "What Goes on Inside" and "Alcoholism—A Wastebasket Revolution."

It seems logical to believe that the "Power that could restore us to sanity" might also have prevented the "insanity," or the alcoholism, if the individual had utilized this Power before he became alcoholic. The above definition might be enlarged to "Alcoholism is a spritual illness caused by a failure to utilize available spiritual powers to solve personal problems.

It should be noted that the experience that produced the Twelve Steps did not indicate that drinking

or alcohol was the basic problem. An outside observer of A.A. might observe that sobriety for the alcoholic is obtained as a result of (a) accepting a Greater Power, (b) self-examination, (c) recognition of social responsibilities and (d) helping others with similar problems. The obvious effectiveness of A.A. leads to the idea that alcoholism is primarily a problem of the person—a personal-spiritual problem; a personal-psychological problem; and a personal-social problem.

If theories are to be judged by the effectiveness of their application. then the "theories" of A.A. cannot be lightly passed over.

3. *Alcoholism is a problem found where inadequate personalities use alcohol for a temporary solution for their inadequacies.* This theory finds support among people versed in the knowledge of human emotions. These people believe that the functioning of emotions, and feelings, and self-control are found in the brain with a probable centering in the frontal lobe of that organ. The satisfying effect of alcohol in the body is one of sedation, anesthetizing, or slowing down these functions. The need for relaxation and the temporary withdrawal from physical and mental activity is recognized as normal. The person who causes a mental and emotional relaxation, through the use of alcohol, to the extent that he endangers his own well-being, must either have greater problems than the normal person or a subnormal ability to meet normal problems. This theory is tested by treatment aimed at reducing the problems that the alcoholic faces and strengthening his ability to cope with these problems.

4. *Alcoholism is the result of a malfunctioning of the physical body in relation to the metabolism of alcohol.* Some people who are versed in the physical workings of the body, and in the addictions that are believed to be physical, are pursuing a theory that there are physical or functional factors in the bodies of alcoholics that set them apart from non-alcoholics. These people are helping alcoholics with the use of drugs and with diet control. They speak of the "X factor" in the admission that the factor is not fully known but also in a belief that such a physical factor does exist. The "physical minded" therapist, even with his undefined "X factor," is helping some alcoholics obtain sobriety. Their successes cannot be passed over lightly.

Areas of Agreement

These three working theories have some things in common. A look at these common denominators may lead us a step closer to limiting the problem of alcoholism. Every successful treatment involves a relationship between a patient and a therapist who takes an interest in him and who has a method of treatment. Conspicuous because of its absence, in every successful treatment relationship, is the rejection and condemnation that is apparent in the non-therapeutic relationship that the alcoholic meets in normal living.

A second area of common agreement is noted. The alcoholic drinks to meet certain needs, without being conscious of those needs. The relaxing effect of alcohol, and the sociability and feeling of refreshment that results, can be accepted as the real motive of most normal drinking. The alcoholic rationalizes that he, too, drinks for these same reasons, but his consumption, beyond normal limits to the extent that he endangers his well-being, seems to indicate that his basic need differs from that of the normal drinker. It is probable that this need difference is quantitative rather than being any different *type* of need.

The common factors of a patient-therapist relationship and an unawareness of real causes, on the part of the alcoholic, lead one to suspect that treatment is successful because treatment supplies some of the needs that alcohol supplied, or perhaps promises to supply them. If the therapy is truly successful, it will provide a temporary bridge between alcohol supplied needs and the normal satisfactions of living that supply these needs for the average person. This idea might well lead to a speculation that alcoholism would not have been present had the patient had available, at an earlier time, the therapeutic bridge between unmet needs and normal satisfactions.

This idea introduces the basis for a different theory in the limitation of the problem. The individual with physical, social, or personal needs, that are not met in ways normal to his society, finds in alcohol a method of meeting these needs, at least temporarily. This "cure-all" remedy, which is socially acceptable to most people as a beverage, does not actually satisfy the need but rather it temporarily removes the drive to find normal satisfactions for normal needs. The alcoholic, like the normal non-alcoholic, is not consciously aware of his needs, nor is he aware of the things he does to meet his needs. Take, for example, a need for recognition and security. Without ever being conscious of these needs, normal people may monopolize conversations, push other people around, or strive in numerous ways to excel in some special area. Eating habits may be dictated by specific diet needs, without a person being particularly aware of those specific needs.

If the alcoholic finds in alcohol a solution for unrecognized needs, and if successful treatment involves a personal relationship that leads to more normal ways of satisfying those needs, one might well theorize that the alcohol problem originated because of the inability of the individual to meet his needs in a normal way and the unavailability of aids or bridges to normal solutions.

This theory leads to a new definition: Alcoholism is a human problem resulting from the excessive use of alcohol as a substitute for meeting normal needs in normal ways.

This theory minimizes the differences between alcoholics and non-alcoholics. It suggests that both have the same needs: physical, emotional, social, and spiritual. It suggests that there are normal ways of meeting these needs. It implies that alcoholism can be successfully treated by (1) finding what needs the alcoholic meets with alcohol, and (2) helping him to find normal ways of meeting these needs.

Idea for Prevention

This theory offers a challenging idea in prevention. If successful therapy is a bridge to other ways of problem-solving, and successful therapists are people who recognize the alcoholic as a sick person and who believe they can be helped, then one could expect that the acceptance of these ideas, on the part of people in the normal environment, might offer help in the early stages of problem-solving through alcohol. This theory offers hope that a broad acceptance of alcoholism, as an illness, might result in the early recognition of the difficulty and a transition to more normal methods of problem-solving.

It is not possible, at this time, to clearly define or limit the problem of alcoholism. There is still a need to pursue every theory on causes and cures. There is real hope in the realization that common factors are emerging from a variety of theories.

The nurse who is able to understand and accept the alcoholic as a sick person can play an important role in helping the alcoholic seek further treatment after he leaves the hospital.

Miss Kinch is an instructor at the Toronto Clinic of the Alcoholism Research Foundation. This article was originally published in Alcoholism, the Foundation's quarterly journal.

THE ROLE OF THE NURSE

IN THE TREATMENT OF ALCOHOLICS IN GENERAL HOSPITALS

BY BETTY KINCH, R. N.

IF the nurse in a general hospital is to do her best for the alcoholic patient, she must understand the important part which her role enables her to play in directing the recovering patient into follow-through therapy. Hospitalization is only the beginning of treatment for the alcoholic.

We still see nurses who have considerable difficulty in accepting the alcoholic as a sick person, who still see him as a weak individual with no will-power, and consider him to be a nuisance to the hospital staff. Unless the nurse is able to radically change this thinking, and this requires much patience and understanding, she cannot help the alcoholic patient. She must be able to accept the alcoholic as he is.

The nurse is probably first going to see the alcoholic patient in the emergency or admitting department. The patient may be in a very intoxicated state, or he may be sober. Regardless of his condition, he is probably a very frightened and anxious person, even to the extent that he may find it impossible to remain for treatment. He fears drinking but he also fears sobriety. Any patient has feelings of insecurity and fear, and it is very frightening for him to suddenly find himself in a situation over which he has no control.

Our role is to decrease the alcoholic's anxiety by offering him reassurance and help as we would to any other sick person. We may see a patient who is dirty, frightened, anxious, hostile, disturbed, and disturbing to all concerned—someone the nurse would rather avoid than approach. We may see the alcoholic reacting quite violently and with much hostility toward the person who has brought him, sometimes against his will, to the hospital. However, it is usually quite amazing to observe the change in this patient's behavior when he is confronted by a nurse who is able to handle her own feelings around such behavior. To this disturbed individual, the nurse seems to represent

a figure who can understand him as a sick person, one who wants to help him, but she *must* make this known to him.

Some patients presenting themselves in the emergency department may not be ready to involve themselves in treatment. They may be quite ill, but just asking for some medication to get them comfortably through a temporary withdrawal from alcohol. But they may have some reservations about their drinking; and the nurse, through encouragement and understanding, may be influential in their returning for treatment at a later date.

Knowledge of D. T.'s

The nurse should know about D. T.'s—the severe and complicating problem of acute intoxication. The patient may develop symptoms—confusion, extreme agressiveness, lack of cooperation, hallucinosis and sometimes epilepsy—either while still drinking or after the beginning of withdrawal. It is important for the nurse to observe the patient closely and to record these symptoms in order that his withdrawal may be handled safely and adequately by the doctor. The nurse can help the patient who is experiencing any of these symptoms by understanding his symptoms and fears and how very real they are to him. She must attempt to convey this understanding and reassure him, realizing that his fears will be greatly increased by solitary confinement and by the use of restraints. Restraining measures should, therefore, only be employed if the patient is a threat either to himself or to others.

A quiet, understanding atmosphere is most helpful in bringing the patient back to the reality situation. Present-day medications control the patient with D. T.'s very effectively and usually he responds quickly. As nurses in the general hospital, you will be seeing a number of patients with D. T.'s, since this is one of the reasons for admitting intoxicated persons, but, from this, do not wrongly assume that most alcoholics develop D. T.'s. It is a fact that only about five percent of the alcoholic population experiences D. T.'s.

The patient's withdrawal is handled with drugs, but only during the immediate recovery stage. The drugs are helpful in reducing his irritability and restlessness. Regarding the use of drugs, nurses must realize that alcoholic patients have an addictive illness and that because of their addiction they are very prone to substitution. At no time should the alcoholic be given large quantities of barbiturates, paraldehyde, bromides or tranquilizers unless it is felt that he can adequately handle them as directed by the doctor. The alcoholic should be made to understand this part of his illness, and it is the role of the nurse to help him to accept the early discontinuance of drugs following his withdrawal and to recognize the dangers of developing drug addictions. Many alcoholics complain of sleeplessness and therefore feel they have a great need to take sleeping pills. The nurse must help the patient to understand that this is a temporary discomfort following withdrawal and that it would be more dangerous for him to continue on drugs.

It is not every patient who, once he is dried out, wishes to involve himself in on-going therapy; but for those who do wish to continue treatment, the ward setting is important. When alcoholics are treated in a setting with other illnesses, many do not feel free to discuss their alcoholism. They need to learn to communicate their feelings and to be accepted by people, but are unable to do this with inexperienced staff

and unsympathetic patients. Too little opportunity is available to learn to understand the illness and something about the patient. Although I feel that the separate unit is the most desirable for the treatment of the alcoholic, it is not always possible, nor should its absence prevent any nurse from playing an important role in helping the alcoholic.

A rigidly regulated ward setting in which the nurse is the authoritarian figure and where patterns of conformity are usually enforced is a poor setting for the alcoholic patient who has usually built up a great deal of resentment toward authority and toward the enforcement of rules and regulations. The nurse should realize that the patient community needs *positive* discipline. Some nurses have rigid attitudes toward discipline and enforcement of regulations; but in this situation the nurse should be flexible and have a ready response to patients' requests. At the Toronto hospital of the Alcoholism Research Foundation, we have as few rules and regulations as possible and our patients are allowed considerable freedom. Certain rules have been made, some as a protection and some in order that therapy can be carried out under the best possible conditions. A patient may be refused permission by the nurse (or referred to some other staff member) to leave the hospital for various reasons—to seek employment, get a haircut, or perhaps just to buy a pack of cigarettes—when there is no real reason for the refusal. It is difficult to persuade some nurses to make their own decisions and, rather than accept the responsibility for allowing a patient to go out, the nurse will refuse his request.

We should be aware of the reasons why some nurses are reluctant to accept this responsibility. Often the nurse is trying to protect the patient, fearing that he may drink while away from the hospital, or she may fear criticism from the other staff members for her decision. The nurse can, however, develop enough confidence in her own judgment to always be aware that whatever her decision, it was made for the good of the patient. Some patients will go out and get into drinking difficulties, but the nurse must understand that her patients will not always be in the protective setting of the hospital. Some patients have to test out their drinking and many benefit from the experience by gaining a better understanding of the compulsive part of their addiction. The nurse can learn skills for handling situations so that her decisions may not be viewed by the patient as hostility or weakness on her part.

Communicating with the Alcoholic

We often see nurses who are guilty of adopting a highly efficient routine. More importance is placed on the expediency of carrying out nursing procedures than on the patient who is involved in these procedures. Rather than hiding behind routine, the nurse can treat these occasions as opportunities to communicate with the patient. The atmosphere of hurriedness may be the nurse's idea of efficiency but it would certainly appear to interfere with the establishment of satisfactory interpersonal relationships with patients. Many nurses feel uncomfortable just talking with patients because so much emphasis has been placed on being busy. Often such nurses are far from being busy, but an impression of "busyness" has been effectively established. As Dorothy E. Gregg has said in her paper on the psychiatric nurse's role, "The patient who feels unworthy and disrespected may need the experience of learning personal worth. The nurse may convey a feel-

ing of respect and an impression of his personal values as she carries out her nursing procedures. Through her manner as well as through verbal communication in these contacts, she can provide the patient with the experience of being accepted."

Whether the nurse is seeing the alcoholic on a short-term or long-term basis, any contact which she has with him is important and she must be aware of what her behavior can convey to him. Sometimes the nurse may move away from situations that are uncomfortable—a readily available defense. Although she may try to avoid the patient whose behavior is bizarre, erratic, or hostile, she needs some understanding of the meaning of this behavior in order to share her observations with other staff members since, in many instances, they rely on her information.

Understanding the Alcoholic

The patient probably sees the nurse as the least threatening of all the staff. He usually sees other members of the staff in the formal office setting which is, in itself, a certain threat to him, whereas he sees the nurse in the less formal setting of the ward. The patient sees the nurse as non-judgmental, non-critical, accepting him as a sick person who can be helped. It is helpful to the nurse to understand what the patient is really seeking—someone with whom he can talk freely without fear of criticism and with whom he feels comfortable; someone with whom it is safe to allow a relationship to develop, one who is understanding, patient and tolerant. The nurse with experience should be able to fulfill these requirements. The alcoholic has a great need for acceptance and should come to know that he is accepted and respected by the nurse as a person in his own right. The nurse should encourage him to communicate his feelings, to examine his thoughts, actions and problems so that he can recognize his needs. The greatest part of the nurse's role is the support and encouragement that she can give the patient.

Often the use of a protective drug plays an important part in the rehabilitation of the alcoholic. The nurse should understand the action of the protective drugs and be able to point out to each patient their usefulness in the treatment of alcoholism. Any protective drug should be given at the request of the patient, and at no time should it be forced upon him, nor should it be given without his knowledge. The patient should understand that the taking of such a drug does not in any way replace the need for active participation in other aspects of a rehabilitation program, including association with Alcoholics Anonymous or other phases of the follow-up program at the clinic itself. Although it is not every patient who may choose a protective drug or who feels it a necessity, the nurse can help each patient accept the fact that these drugs can play a very useful part in rehabilitation. This is when the patient can be made to realize that his recovery from alcoholism should be thought of as a long-term proposition; that his use of alcohol is only a symptom and a complicating factor of his illness; that sobriety is only one part of his treatment; and that adequate and sustained treatment and follow-up therapy are indicated for a good recovery.

On discharge, a patient that a nurse has tried to help may appear to be making considerable progress in his rehabilitation, but perhaps before long he returns apparently back where he started from. This is where it is helpful for the nurse to look at his recovery in terms of degrees

of improvement. Many patients seem to have to test out their drinking again. Perhaps this is the first time this person has ever tried to stop drinking and any period of sobriety is some improvement. Here the nurse can encourage the patient by pointing out this improvement and showing him that, although he has had a relapse, at least he has returned for further treatment and she is willing to support him in his continuing quest for sobriety.

The nurse, of course, is going to see many repeaters, perhaps some whom she has come to know quite well, whom she wants to help, and with whom she can sympathize. Here we see nurses who get "caught up" in their own feelings. They want so badly to do something for this individual, but feelings should not take the place of better judgment. Limits must be put on the individual patient. Admission may not always be possible or advisable in that a dependence on the hospital is being fostered, encouraging the patient to repeat performances. Although it is sometimes difficult to do when the patient who is drinking has sought out a particular nurse, it is necessary for that nurse to make the patient understand that she is available to help him in his recovery but not to support him when he is drinking. Consistency is a vital factor in putting limits on a patient who is still drinking, but it must be used in such a way that it will not be interpreted as rejection. An obvious sense of caring should be conveyed but, at the same time, the patient must be made to understand that no rehabilitation can be started until he has attained sobriety.

There will be many times when the nurse encounters the alcoholic in the general hospital when he is presenting himself with some other illness or injury. In this situation, the nurse with experience can play an important role, even though it may be impossible to build up an intensive treatment relationship. We sometimes see a patient admitted to either medicine or surgery and, during his hospitalization, we find that he is dependent on alcohol to the extent that it may be interfering with or preventing his recovery. Increasingly, too, alcoholism is being seen among patients in tuberculosis sanatoria. If the doctor or the nurse were experienced in this field, he or she, through gaining the patient's trust, could easily approach him and help him to bring his problem into the open. Actually, these people are often sicker with their alcoholism than with the illness for which they have been admitted, and yet we still see nurses and doctors going blindly on not even wanting to recognize the problem, let alone wanting to do anything to help.

Interest in the Alcoholic

Any doctor or nurse should be able to approach an obviously intoxicated patient in a hospital and at least offer him help. The symptoms of alcoholism should not at any time be disregarded. Perhaps the patient isn't ready to stop drinking or to involve himself in treatment immediately, but with some interest and understanding from the nurse, he will know that here is a place where he is accepted as a sick person and a place where he can eventually receive treatment.

Many more suggestions regarding the nurse's role could be made. I have attempted to present a concept of the alcoholic and a possible approach to the problem. The nurse who gains and uses knowledge and understanding effectively can contribute greatly in helping the alcoholic, his family, and other members of the community.

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THE FAMILY AND THE ALCOHOLIC

BY REV. JOSEPH L. KELLERMANN

EXECUTIVE DIRECTOR
CHARLOTTE COUNCIL ON ALCOHOLISM

The family's best defense against the emotional impact of alcoholism is gaining knowledge and achieving the emotional maturity and courage needed to put it into effect.

AN article, "Do's and Don'ts for Wives of Alcoholics," has been reprinted and widely circulated for several years. Its principles are valid for all who deal with alcoholics—family, friends, or professional persons.

No single article is adequate, yet each may give some bit of information to the public knowledge and education in the field of alcoholism. This article will attempt to be a "guide" for the family seeking help in an effort to deal more adequately with an alcoholic within the family.

The basic problem is gaining knowledge and then achieving the emotional maturity and courage to put this knowledge into effect. Individuals who may be capable of assisting alcoholics outside the family may become confused, destructive persons if a member of their own family becomes an active alcoholic. This is especially true if the drinking alcoholic is the husband or wife.

The "next of kin" or person closest to the alcoholic may need more assistance and counseling than the alcoholic if an effective recovery program is to be launched. Alcoholism is an illness, but one which has tremendous emotional impact upon the immediate family. Those most affected by the alcoholic are the spouse, parent, sister, brother, and child. The more distorted the emotions of these persons become, the less adequate their help will be. The interaction may and often does become destructive rather than helpful.

For example, wives may find themselves blamed for everything that is wrong in an alcoholic marriage. This may reach the point where they may fear this is true. Yet alcoholism is an illness. The wife is no more responsible for alcoholism than she would be for the existence of diabetes or tuberculosis in her husband. No wife ever made her husband an alcoholic, therefore no wife can "unmake" her husband, or be held responsible for his recovery. However, by lack of knowledge she may allow the illness to go unnoticed. By lack of adequate understanding and courage she may acquiesce in the development of the disease. The wife is not responsible for the existence of her husband's alcoholism, but she can take steps which may lead him to earlier recovery, though this cannot be absolutely assured.

This same principle holds true for all members of the family, especially the one person upon whom the alcoholic ultimately depends. This primary person in the alcoholic's life cannot "treat" the illness. No doctor should treat his own serious illness, and few will ever act as physician for a member of their immediate family, especially spouse, parent or child. As alcoholism progresses, relatives become involved emotionally. The best help they can give initially is to seek help and treatment for their own situation so that they will not play into the progressive illness pattern of the alcoholic and thereby contribute to the progress of the illness rather than recovery. The mistakes made by well meaning family members are almost unbelievable and often make recovery most difficult for the patient.

It must be understood in the beginning that a family may do everything known or thought to be right and the illness might go unchecked. However, if a family is willing to learn the facts about alcoholism and put them into effect, the chances of recovery are greatly increased. In fact, the best way to help any alcoholic recover is to remove ignorance, acquire an adequate attitude based on knowledge and have the courage to practice these principles when dealing with the alcoholic. To begin in the usual manner of attempting to force the alcoholic to stop drinking without first learning and changing one's own self will simply make the matter worse.

Initially we must understand that the problems of alcoholism do not lie in the bottle but in persons. However, recovery does not begin until the alcoholic is able to break away completely from the bottle and practice continued abstinence. Recovery is also similar to the construction of a Gothic arch. There are unseen foundations; many persons may lay various stones in the arch; but the keystone must be put in place by the alcoholic or the structure falls. No one can do *for* the alcoholic what must be done *by* the alcoholic. You cannot take the patient's medicine and expect the patient to benefit. Choices must be made and action taken by the alcoholic of his own volition if recovery is to occur on any permanent basis.

It is appalling how well the alcoholic controls the family, especially the wife, husband or mother. The alcoholic drinks again and again. The family screams, cries, yells, begs, pleads, prays, threatens, or practices the silent treatment. It also covers up, protects and shields the alcoholic from the consequences of his drinking. If the alcoholic continues to act like a little god, it is because the family is inadequate in opposing this attitude and abets the preservation of the illusion of omnipotence.

In the preservation of this omnipotent neurosis the alcoholic has two primary weapons. The family must learn to defend against these two weapons or become virtual slaves to the illness thereby creating for themselves emotional or mental illness of no small proportion.

The Alcoholic's Weapons

The alcoholic's first weapon is the ability to arouse anger or provoke loss of temper. If the family member or friend becomes angry and hostile, this person has been completely destroyed insofar as ability to help the alcoholic is concerned. Consciously or unconsciously the alcoholic is projecting an image of self hatred onto the other person. If he is met by angry, hostile attacks, the image is thereby verified, and the alcoholic in his own mind justifies his former drinking and also now has an additional excuse to drink in the future. The gods first make angry those whom they wish to destroy, and the alcoholic has a long experience of acting like a little god. If your temper is lost, all chance of help at this time is thrown away, at least for the moment.

The second weapon of the alcoholic is the ability to arouse anxiety on the part of the family. An anxious family is compelled to do *for* the alcoholic that which must be done *by* the alcoholic if the illness is to be arrested and recovery initiated. A "bad check" is a good illustration for this principle. The check may be written before, during, or after the drinking period. The alcoholic does not have money in the bank to redeem the check. When the anxiety of the family members becomes too intense as regards what will happen if the check is not redeemed, they

secure money and cover the check. This relieves the alcoholic and the anxiety of the family, but it establishes a pattern for the alcoholic in the area of problem solving. The alcoholic now learns that his family is not going to let him suffer the consequences and he may expect this to be done whenever a bad check is written.

More important still, if the check is redeemed by others, the alcoholic cannot redeem it and therefore this failure is made permanent. The alcoholic cannot undo what others have already undone. This, in reality, increases the alcoholic's sense of failure and guilt, and increases the family's sense of hostility and condemnation of the alcoholic. Thereby the alcoholic is doubly injured. The criticism, scolding and moralizing add to the alcoholic's guilt and resentment against self and family. The entire situation is thus made worse. The family verbally condemned the writing of the "bad check" but, at the same time, gave a form of approval to the act by "making it good."

Alcoholics are propelled along the progress of the disease when the family is unable to cope with anxiety aroused by the alcoholic. This is in effect part of the illness. Neither the alcoholic nor his family is able to face reality. The writing of the bad check and the redemption of it by the family are but two sides of the same problem. The alcoholic can never learn to solve his own problems in a responsible way if the anxiety of the family compels the removal of the problem before the alcoholic can be brought to face it and solve it or suffer the consequences. This "home training course" increases the alcoholic's irresponsibility, and thereby increases the hostility, resentment and tension between the "patient" and the family.

Anger and anxiety must be avoided by the family or the family contributes to the progress of the illness. The family members must first learn to cope with their own problems before any beneficial effects can reach the alcoholic. This requires help just as any serious illness requires help outside the family from doctors, nurses etc. The alcoholic can continue to deny that he has a drinking problem and that he does not need help as long as the family provides an automatic escape from consequences of drinking.

Help for the alcoholic and for the family should be sought outside the circle of relatives, friends, and neighbors. Preferably it should come from persons trained in this area of work or from experienced members of Alcoholics Anonymous or Al-Anon. Home remedies for alcoholism are notoriously injurious. The illness is so serious it will shorten human lives ten to twenty years if it goes unchecked.

Love and Compassion

One of the more serious failures in approaching the alcoholic is the inability to understand the meaning of love. The wife has no more right to state, "if you loved me you would not drink," than she has the right to say, "if you loved me you would not have tuberculosis." Excessive drinking reveals the existence of the illness, but illness is a condition, not an act. It is not far from the truth that the alcoholic himself feels unloved and unwanted and not without reason. Love cannot exist without the dimension of justice. Love must also have compassion, which means to bear with or to suffer with a person. Compassion does not mean to suffer because of the injustice of a person. Yet injustice is often suffered repeatedly by families of alcoholics.

Alcohol is an anesthetic. When the

alcoholic drinks, he anesthetizes his pain. This is the pleasure of alcoholic escape. It is a problem solving device to relieve unpleasantness, anxiety, tension and resentment. When the alcoholic drinks, pain is avoided for the time being, but pain, tension, anxiety and resentment are increased severely in the family. When the alcoholic sobers up, there is little desire to suffer the consequences of drinking. Remorse and guilt now compel the alcoholic to prostrate himself before the family, beg for mercy and promise that it will never happen again. Or the reverse side of the coin may appear—complete unwillingness to discuss what happened. Each side attempts to gain the same goal, the avoidance of the consequences of drinking. If the alcoholic succeeds by any means, his pain is again avoided or relieved and the family again pays the price of the consequences of drinking.

Love is Destroyed

Love cannot continue to exist in this type of action and interaction. The alcoholic uses alcohol to escape pain by drinking and learns how to use the family to escape the pain of the consequences. The family suffers when the alcoholic drinks and then suffers the painful consequences also. If the family bears the brunt of the drinking and absorbs its consequences, then compassion cannot exist. Compassion is bearing with or suffering with a person, not suffering because of the unwillingness of the other person to suffer. If this state of affairs is allowed to continue by the family, love is gradually destroyed and replaced by fear, resentment and hatred. The only way love can be retained is by family members learning not to suffer when drinking is in progress and refusing to undo the consequences of drinking. Anything less than this is not compassion and any relationship without justice and compassion is not love.

Knowledge of the nature of alcoholism as an illness and the courage to live by this knowledge is essential if fear is not to replace love in marriage. Unfortunately, many families suffer repeatedly from drinking and its consequences, thinking this is required if they love the alcoholic. The tragic result is that alcoholism is thereby encouraged and fear and resentment take over human emotions. This is why family members, especially the next of kin to the alcoholic, need help if the disease is to be arrested and recovery initiated. Otherwise, the entire family becomes ill emotionally. This condition is but another symptom of the progress of the disease.

Before leaving this area of discussion, it is necessary to state that there are wives who need alcoholic husbands or husbands who need alcoholic wives to gratify their own neurosis. This may be true of parents, or brother and sister as well. The family must always take a close look to be certain this need does not exist. Masochism is the need to suffer in order to find a sense of worth or value in life. It is all too often seen in wives and mothers of alcoholics who use an alcoholic in order to suffer. Some persons are sadistic and must have someone available to punish, and an alcoholic serves this purpose well. Others like to dominate and control other persons. Alcoholics provide a fit subject for exercising such control and dominance. If any of these three conditions exist, then the non-alcoholic may have a far more serious illness than alcoholism which must be treated and arrested before it will be possible for this person to do anything other than contribute to the progress of alcoholism.

A wife, husband or family member needs to take a good look at their own involvement with the alcoholic before any steps should be taken to aid in abstinence from alcohol. In most instances, a change in the family is necessary before a change in the alcoholic may be anticipated. To do nothing is impossible. As a general rule to do nothing means to give in to the situation, to be run over and exploited and to fight back in quiet, passive, destructive ways. The family always interacts with the alcoholic. The important thing is to learn which interactions are destructive and which might be creative and then have the courage to attempt a creative approach. The change must begin with the non-alcoholic. The alcoholic will not seek help in recovery as long as his needs are met within the family.

Long-range Sobriety

A frequent mistake is to attempt to protect the alcoholic from alcohol by bending every effort to keep him away from the bottle and the bottle away from him. This cannot be achieved short of incarceration or commitment and even under these circumstances some manage to find alcohol. It is hard for the family to learn not to try to prevent the drinking, but any battle they win today over the bottle will be fought again tomorrow. Winning the war against the overall illness is the objective. Motivating the alcoholic to have a desire to stop drinking and to accept help in this effort is far more effective than trying to take the bottle away. The only way this motivation can be accomplished is by allowing the drinking and all its consequences to become so painful in itself that the alcoholic will seek escape from the intolerable pain caused by drinking. This means offering the alcoholic love and understanding in his sobriety, but not protecting him from the bottle or the consequences of drinking. This means suffering, but suffering with him in pain of the consequences, not by becoming the means of his escape from consequences. This means the courage to suffer embarrassment, small or great financial deprivation, loss of job, and in some instances temporary separation in various and sundry ways. We must offer greater joy in sobriety and allow the painful consequences to become acute if we anticipate ultimate long-range sobriety.

Recovery from any serious illness may involve considerable time and on occasions there may be relapses. The world has not come to an end if, after a period of sobriety, the alcoholic drinks again. If the family does not panic and revert to the former destructive means of dealing with the problem, the "slip" may be used to advantage and become an additional reason for the alcoholic to accept the fact that the first drink must be avoided.

In the process of recovery, it is not realistic to expect all compulsive action to disappear overnight. The alcoholic may become as engrossed in his treatment and recovery as he was a short time ago in his drinking. This is especially true if he finds and accepts Alcoholics Anonymous. The alcoholic husband or wife may now spend each evening with these recovered alcoholics. The best bet against resentment in this area is for the spouse to join Al-Anon, and attend open A. A. meetings. Al-Anon, the group for family members of the alcoholic, is just as vital to the emotional recovery of the family as A. A. is to the alcoholic. It attempts to provide insight and understanding into the problems of its own members. If a family wishes the drinking member to stop drinking and join A. A., they might first try

Al-Anon and attend open A. A. meetings themselves. Recovery from alcoholism involves the healing of the emotional illness of all members of the family. If the alcoholic recovers emotionally and family members do not, there may be a serious breach in the family structure. The family must grow up emotionally before, during, and after the alcoholic recovers or serious estrangement may occur. The time for the family to begin working out its own emotional recovery is now.

Begin with Self

The place to begin in helping an alcoholic recover is with self. Learn all you can. Put it into practice, not just into words. This will be far more effective than anything you attempt to do for the alcoholic.

In summation, there are several rules of thumb which may be observed.

1. Learn all the facts and put them to work in your own life. Don't start with the alcoholic.

2. Attend A. A. meetings, Al-Anon meetings and, if possible, go to a Mental Health Clinic, Alcoholism Information Center or to a competent counselor or minister who has had experience in this field.

3. Remember you are emotionally involved. Changing your attitude and approach to the problem can speed up recovery.

4. Encourage all beneficial activities of the alcoholic and cooperate in making them possible.

5. Learn that love cannot exist without compassion, discipline and justice, and to accept it or give it without these qualities is to destroy it eventually.

It is easier to find a list of don'ts in dealing with alcoholics, for it is easier to understand why you fail than to know why you succeed. The following list is not inclusive but it makes a good beginning.

1. Don't allow the alcoholic to lie to you and accept it for the truth, for in so doing you encourage this process. The truth is often painful, but get at it.

2. Don't let the alcoholic outsmart you, for this teaches him to avoid responsibility and lose respect for you at the same time.

3. Don't let the alcoholic exploit you or take advantage of you, for in so doing you become an accomplice in the evasion of responsibility.

4. Don't lecture the alcoholic, moralize, scold, praise, blame, threaten, argue with him when he is drunk or sober, pour out liquor, lose your temper or cover up the consequences of his drinking. You may feel better but the situation will be worse.

5. Don't accept his promises, for this is just a method of postponing pain. In the same way don't keep switching agreements. If an agreement is made, stick to it.

6. Don't lose your temper and thereby destroy yourself and any possibility of help.

7. Don't allow your anxiety to compel you to do what the alcoholic must do for himself.

8. Lastly, don't try to follow this as a rule book; it is simply a "guide" to be used with intelligence and evaluation. If at all possible, seek good professional help. You may need it as well as the alcoholic.

9. Above all, don't put off facing the reality that alcoholism is a progressive illness that gets increasingly worse as drinking continues. Start now to learn, to understand, and to plan for recovery. To "do nothing" is the worst choice you can make.

Reprinted by permission of the author from a booklet entitled "A Guide for the Family of the Alcoholic" published by the Charlotte Council on Alcoholism, Inc.

CASEWORK with the Alcoholic Patient

The author is Chief Psychiatric Social Worker in the Adult Guidance Center of the Department of Public Health, San Francisco, California. This article was originally published in the February, 1956 issue of Social Casework.

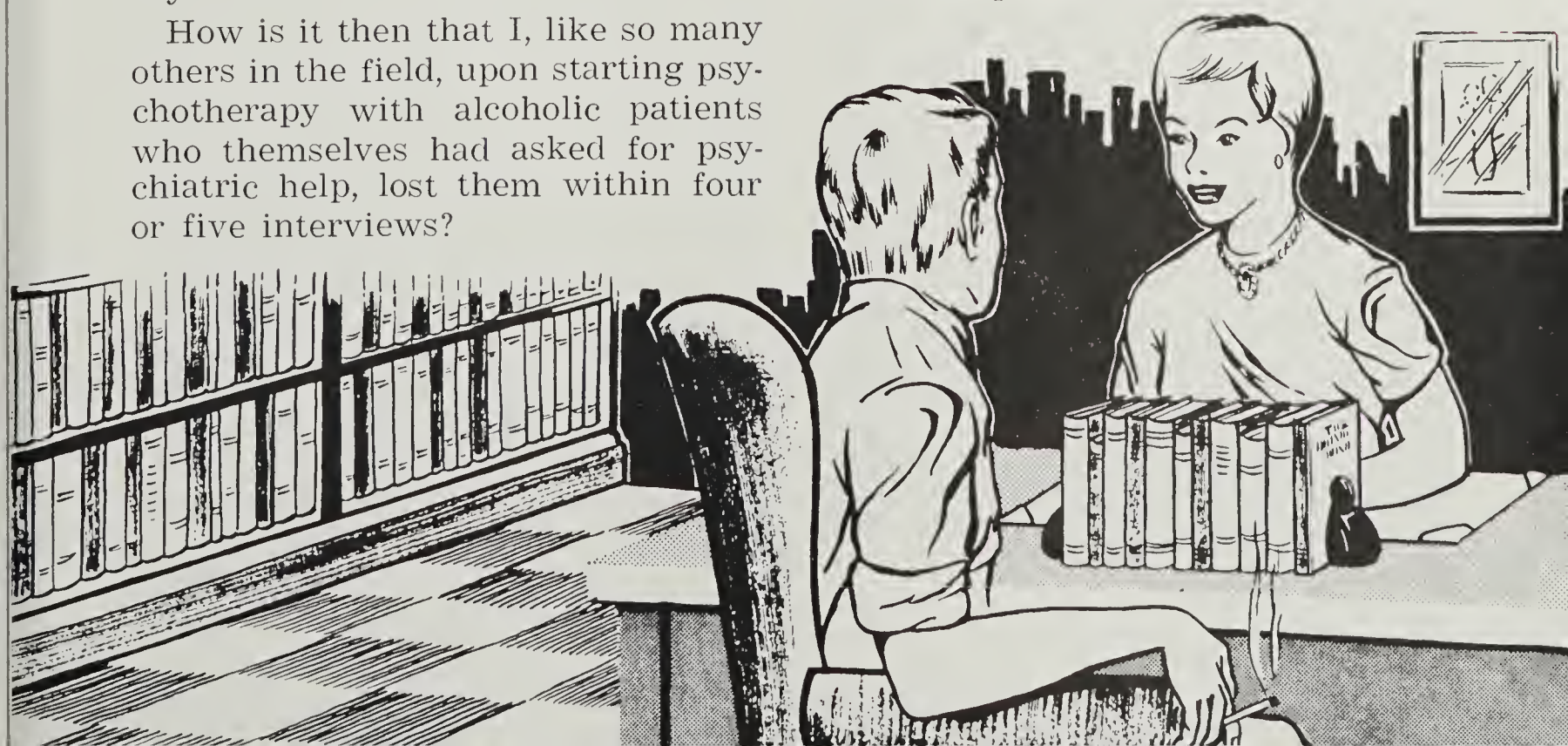
BY CATHRIN M. PELTENBURG

The successful therapist is able to control and direct her reactions.

IN essence, the treatment of the alcoholic patient is no different than the treatment of any other disturbed person. If this is so, why, then, is it that case workers, psychiatrists, psychologists, so often fail in their attempts to help the problem drinker? Certainly, inferiority-superiority conflicts, extreme dependency needs, demandingness and manipulation, confusion regarding sexuality, guilt, self-rejection, self-destructive tendencies, and low frustration tolerance are common enough in other neurotic patients. And the casework done with the alcoholic person is based on exactly the same principles of good listening, respect, acceptance, nonjudgmental attitudes, and empathy.

How is it then that I, like so many others in the field, upon starting psychotherapy with alcoholic patients who themselves had asked for psychiatric help, lost them within four or five interviews?

I began to see that my difficulty in treating alcoholic patients arose not from any qualitative difference between their emotional problems and those of other patients, but from the peculiar intensity and urgency of these problems in alcoholics which not only necessitated modifications in therapeutic approach, but which also exposed the therapist to certain pitfalls in the area of his own reaction. For instance, the alcoholic patient often feels demoralized and hopeless to such an extent that his demoralization can become conveyed to the therapist who then feels helpless and easily becomes defensive and critical. The extreme degree of dependency and helplessness displayed by the patient, of demandingness



and manipulation, of quiet sabotage and expectance of a magic cure without participation, can wear down and exasperate the therapist who is not always sufficiently aware that his patient, overwhelmed with guilt and self-condemnation, expects and "needs" rejection. And since the alcoholic patient is an unsurpassed master at provoking rejection, he only too frequently suceeds in doing so.

There is the patient whose circumstantiality and evasiveness all but wear out the therapist's patience unless he understands that this behavior is part of his protective armor. This patient's frequent grandiose ideas about himself where he has nothing but failure to show, his submissiveness to the point of servility or, on the contrary, his covert or overt hostility and condescension, put the therapist to a real test. For the therapist not to recognize his own frustration and annoyance, and thus not to deal with it, is a severe handicap in treatment.

Then there is the traditional misinterpretation of alcoholism as a moral weakness. The alcoholic patient himself frequently emphasizes his moral "depravity" and his lack of character and tries to have the therapist agree with him in an attempt to reestablish his familiar role of the bad boy (or girl) at odds with the authorities. A brief remark like "I'm not here to judge, I'm your therapist" shifts the focus from a moral to a therapeutic approach to the problem, implicitly relieves guilt, and stimulates the patient to think more constructively.

Another difficulty sometimes shared by patients and therapist alike is that they may equate sobriety with therapeutic success. This tends to make the therapist over-anxious to keep the patient "dry," with the disatrous result that the patient may turn to drinking as a weapon of retaliation against the therapist whenever negative feelings emerge. The therapist by reacting to the patient's drinking as so many people have reacted to it in the past makes it difficult for the patient to react differently to it himself. The relationship of the bad boy (or girl) to a disapproving society is perpetuated. This does not mean, however, that one should not take a position regarding whether or not a patient drinks. The therapist unequivocally supports the view that there is no cure for alcoholism, in other words, that the patient cannot become a social drinker, that he will have to give up drinking entirely if he wants to arrest the process of progressive alcoholism.

Modifications in Technique

What is meant is that the therapist sometimes gets unduly anxious regarding the patient's drinking. This is at variance with our usual therapeutic attitudes. We would hardly expect a person who has never been able to keep a job to lose this symptom the moment he entered therapy, yet we sometimes seem to feel that an alcoholic should not drink any more immediately after starting treatment.

In addition to presenting emotional problems to the therapist, psychotherapy with alcoholics calls for certain modifications in technique. The alcoholic's guilt, discouragement, and anticipation of failure and rejection, necessitates a more active approach than the usual passive, receptive attitudes. A mere "interested listening" is not enough. The therapist must work to establish quick rapport and a feeling of trust on the patient's part if he is to keep him as a patient. There are several ways in which this can be achieved.

With the common prejudice of the

alcoholic that no one but an alcoholic can understand his problem, it will be necessary for the therapist to give some indication, somehow, that he understands that the patient's drinking is often beyond his control; that he knows what agonies—mental moral, and physical—the patient is going through; that he realizes how strong the patient's need to drink must be to outweigh the consequences of arrests, debts, loss of wife, home, and self-esteem. It is further extremely important to be alert, or as I call it "to hunt," for signs of achievement—a good work record, for instance, or the fact that he has merited respect from a boss "who always takes him back"—and to comment on these facts with recognition. This is an exceedingly valuable means of establishing rapport and has the additional value of rekindling the patient's extinct self-esteem which is the first step toward recovery in that it brings hope to an utterly discouraged person.

Actually, building self-confidence and self-tolerance is, I think, the most important aspect of treatment. To do this a positive relationship between patient and therapist is essential. Since the alcoholic patient cannot well tolerate his aggressiveness and anger, the emotional support of the therapist is necessary while the patient experiences these unpleasant emotions. When such support is given and maintained despite the patient's unconscious machinations to be rejected, it enhances his confidence in himself and enables him gradually to tolerate more of his own emotions.

Another difficulty that must often be overcome at the beginning of treatment is the alcoholic's tendency to isolate his drinking from his psychic life, to regard it as a mysterious foreign body entirely beyond his control. He is the patient who describes his drinking habits and then sits back with an "and now you cure me" attitude. The unperturbed therapist may combat this attitude through interested questioning about the patient's onset of drinking and his relationships with others at that time, through conveying to the patient that he actually does drink to produce some effect—to be more at ease with a girl friend or to ameliorate his feelings of depression, for example. This tends to set him thinking and to start his participation in the therapeutic process.

In view of what has been said earlier, it is obvious that it is necessary to make concessions to the patient's demanding attitudes in early treatment. Whenever demands cannot be granted, "giving" in another area should be attempted to prevent the patient from feeling rejected, and the anger of disappointment with which he reacts to necessary frustrations should be dealt with so that these emotions will not disrupt the therapeutic relationship.

With those patients who minimize their problems, who only want medical treatment ("just a couple of shots will do it"), I find that outright disagreement ("I don't think they will, no shots on earth will do it for you") startles them into awareness that, maybe, they will have to do their part. I frequently add that, with fifteen or twenty years of drinking, they have quite a battle ahead of them but that it can be won and this largely depends on how convinced they are of the seriousness of their problem.

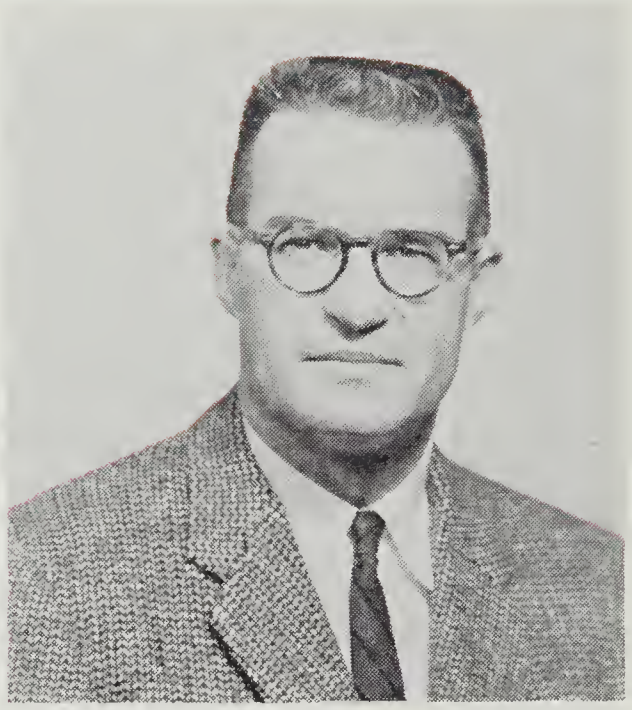
With the unsophisticated patient I do not speak about individual therapy but simply offer them a return appointment and, if this is accepted and well used, I ask if they would like to continue coming on a regular basis. This gives the person who has

(Continued on page 31)

PROCEDURES FOR HOSPITALIZATION

of the MENTALLY ILL in NORTH CAROLINA

BY EUGENE A. HARGROVE, M.D.
COMMISSIONER OF MENTAL HEALTH
STATE OF NORTH CAROLINA



● *Procedures for hospitalizing the mentally ill are governed by law.*

THERE are more patients being treated in mental hospitals today than in all other types of hospitals combined. An estimated half-million people need to be hospitalized for mental disorders, but aren't. Countless more are in need of psychiatric help although their illness is not so severe as to require hospitalization.

This incomplete picture of the nation's number one health problem, though distressing enough in itself, is complicated further by the stigma attached to mental illness.

Stigmas have been placed on illnesses by society and handed down from generation to generation since time immemorial. Stigmas, as they relate to illnesses, may be defined as social judgments based on superstitions, ignorance or fear — but seldom facts. A stigmatized illness carries with it the connotation that it is, somehow, a disgrace to have a particular illness with the result that its victims feel, to their detriment, that they have to hide their condition and hesitate to seek treatment. In other words, mental illness, unlike ulcers, for example, is not socially approved. Ulcers in the popular mind, although they stem from emotional causes, are status symbols of hard work and success. And few people, if any, who are troubled by ulcers would hesitate to seek treatment. Such, all too often, is not the case with mental illness. An example of another currently stigmatized illness is alcoholism; and an example of a stigmatized illness in which the stigma has been largely, though not completely, overcome is tuberculosis.

Needless to say, mental illness is a big enough problem for the individual to overcome without having to fight the stigma as well. Fortunately, there is evidence that the stigma attached to mental illness is gradually succumbing to education, medical advances in treatment, and improved facilities for the hospitaliza-

tion and care of mentally ill patients. Education, however, is by far the most important weapon—for of what use are facilities for hospitalization and treatment if they are not used by the people who need them?

The purpose of this article is to review briefly the procedures for admitting patients to mental hospitals that are incorporated into North Carolina laws relating to the hospitalization of the mentally ill. As you will see, this information is necessary to the individual who has decided that he needs hospitalization, to the family and friends of a mentally disturbed person who may have realized his plight and wish to guide him toward hospitalization, and to physicians whose role in hospitalization procedures is crucial.

The three functions that any law governing hospitalization for the mentally ill should provide to an individual were spelled out almost a century ago by Dr. Isaac Ray. They are: maximum opportunity for prompt medical care, protection against emotionally degrading or harmful treatment such as trial by jury or jailing, and protection against wrongful confinement and deprivation of rights. We believe these functions should still be the basis for laws today.

A good mental health code should be based on accepted concepts of sound legal and medical procedures since both the community and individual must be protected. Hence, our code needs constant revision to keep pace with social, legal and medical advances.

To be specific and for practical application, we believe that a mental health code should provide at least four types of admission procedures: voluntary hospitalization, hospitalization on medical certification, hospitalization by emergency procedures, and hospitalization on court order.

At the present time the law of North Carolina allows three types of admission to its psychiatric hospitals: voluntary, emergency and court order. Medical certification, as an admission procedure, was incorporated into our present mental health code by the 1961 North Carolina Legislature. It will go into effect January 1, 1962.

Voluntary

Approximately thirty-five per cent of current admissions to our state psychiatric hospitals are voluntary. Interestingly, this is well over fifty per cent of the national average—a fact in which North Carolina can take pride. However, we would like to see the voluntary admission procedure used even more.

In voluntary admission as a procedure for hospitalization, the patient, after first procuring a letter from his personal physician recommending admission, signs himself in and agrees to remain in the hospital under observation and treatment for a thirty-day period. At the end of this period the patient may leave if he chooses, even if the advice of his physician is to the contrary. The patients, however, usually follow the physician's advice and remain in the hospital if further treatment is indicated.

On Court Order

The most frequent type of admission to our state psychiatric hospitals is by court order with sixty-three per cent of our patients being admitted in this manner.

Briefly, the procedure for admission by court order consists of three steps: some reliable citizen, usually a relative of the patient, must go to the clerk of Superior Court and sign an affidavit stating that he believes the patient is mentally disturbed and

needs admission to a hospital. Two licensed physicians must then examine the patient. If they, too, believe that the patient is mentally disturbed and needs observation and treatment in a psychiatric hospital, they sign an affidavit to that effect. The third step is an informal hearing held by the clerk after he has served a notice of the hearing on the patient. At the hearing, the clerk examines the patient and the affidavits and may then issue an order of commitment which hospitalizes the patient for a period not exceeding sixty days. If at the end of this time the patient is ready to leave, and the majority are, he is discharged and the court is notified. If not, the superintendent of the hospital sends a statement to the clerk recommending further treatment, and the clerk may then commit the patient for 120 days. Although chronically ill patients may be committed indefinitely after six months, they have the right of habeas corpus and may go before the Superior Court at any time to be examined by the judge who may uphold or rescind the commitment order.

Emergency

The third type of admission to North Carolina psychiatric hospitals is by an emergency procedure which may be used if a patient becomes suddenly and violently mentally disturbed. Usually this means that he is actively homicidal or suicidal and in need of immediate hospitalization. At the present time, two per cent of our patients are admitted by this procedure. We are glad that this kind of admission is available, but we would like to see it used strictly in an emergency situation.

The emergency procedure for hospitalization allows the patient to be admitted for a twenty-day period of observation either through an affidavit of one physician or through an order of the clerk of Superior Court. Only one or the other is required —not both. If the patient is in need of further care after the twenty-day period is over, the usual court commitment takes place or the patient may voluntarily remain.

It is interesting to note at this point in our discussion, that, at the present time, eighty-five per cent of first admissions to our psychiatric hospitals are ready to be discharged within ninety days. Though this good record is somewhat blighted by the fact that forty-nine per cent of the patients are coming back to the hospital later for further treatment, we must remember that the tendency to relapse is not a phenomenon associated exclusively with mental illness but is quite common among many other illnesses. A partial explanation of the relapse rate is that the resocialization and rehabilitation of the patient are incomplete even though, medically speaking, he no longer needs the facility of hospitalization. After discharge, many patients return to the same environment which contributed to their illness in the first place, lose confidence in themselves, and a relapse occurs.

With the recent advances in treatment of the mentally ill and the shortening of hospitalization we feel there is a need for more emphasis on admission as a medical procedure, and are pleased that medical certification will soon be added as the fourth type of admission procedure to the psychiatric hospitals of North Carolina.

Medical Certification

Medical certification, as a procedure of admission, allows hospitalization for sixty days whenever two physicians certify that, in their opinion, the patient is mentally ill and in need of care which a psychi-

atric hospital affords. It applies mainly to patients who will not or cannot come to the hospital voluntarily, but who will come without protest on the urging of family and the advice of their personal physicians.

South Carolina has successfully used this kind of hospitalization for six to seven years and, at the present time, approximately eighty per cent of admissions to their hospitals are by medical certification.

This procedure, like voluntary admission, more nearly allows us to consider the patient as a sick person in need of medical treatment and not as a criminal in need of incarceration. Often with legal commitment there is considerable stigma along with social and family disruption. Many patients after being discharged are thankful that there are no legal proceedings or court commitments hanging over them.

Medical certification, while emphasizing the medical approach and deemphasizing formal court action, does, however, hold such court action in readiness where necessary for the protection of the patient. And if the patient or any member of his family objects to admission through medical certification, this procedure cannot be used and regular court action must be taken.

We believe, over-all, that North Carolina has an exceptionally good mental health code, particularly since medical certification will be added in the future. Then we will have a law which is humane and progressive, which provides maximum reliance on medical judgment, and which protects the patient from degrading experiences at the same time it protects him against wrongful confinement.

Casework With the Alcoholic Patient

(Continued from page 27)

no understanding of what casework or therapy means a chance to find out what "talking treatment" can do for him.

With the psychiatrically sophisticated patient who specifically requests psychotherapy, the intake interview and further treatment can be conducted more nearly as it would with a non-alcoholic neurotic patient. Such a patient is better equipped and prepared to tolerate a passive approach on the therapist's part than are most alcoholics.

It will be evident from this paper that a deliberately planned active approach on the part of the therapist at the onset of therapy is necessary in most cases and that it often means the difference between keeping a patient in treatment and losing him. It is further interesting to consider that differences in approach diminish, or even disappear, not only where greater motivation on the patient's part exists, but also where treatment has continued for some time and the patient has developed greater tolerance for frustration, lost some of his fear of facing himself, and gained greater confidence.

Nothing has been said about the perfectionist attitude which we so frequently find in our patients, nor about the psychopathic personality whom, in some cases, I did find treatable. Neither have I mentioned the importance of working with the non-alcoholic spouse which so often results in striking improvement in the patient, even where the patient himself does not receive treatment. Many other aspects could have been highlighted.

Currently In North Carolina there are twelve

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—
Citizens' Committee on Alcoholism
SGT. CARROL R. OWENS, CHAIRMAN
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
DON DANCY, EDUCATIONAL DIRECTOR
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
MRS. MARGARET RALLINGS, EXECUTIVE SECRETARY — Phone: 942-7253

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
REV. JOSEPH KELLERMANN, DIRECTOR
WILLIAM HALES, ASSOCIATE DIRECTOR
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
211 SNOW Building
MRS. OLGA DAVIS, EXECUTIVE DIRECTOR — Phone: 682-5227

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. GRIFFIN, JR.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade— Phone: BRoadway 4-1295
WORTH WILLIAMS, EXECUTIVE DIRECTOR

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
REV. EDWARD LAFFMAN, DIRECTOR

NEWTON—
Educational Division, Catawba County ABC Board
REV. R. P. SIEVING, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
119 N. Scales St., P. O. Box 355
MRS. ANNE WALL, EXECUTIVE SECRETARY—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
PETER COOPER, DIRECTOR
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
REV. MARTIN CALDWELL, DIRECTOR
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
MARSHALL C. ABEE, EXECUTIVE DIRECTOR — Phone PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

VOL. 11, NO. 4 NOV.-DEC., 1961

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Letters to the Program

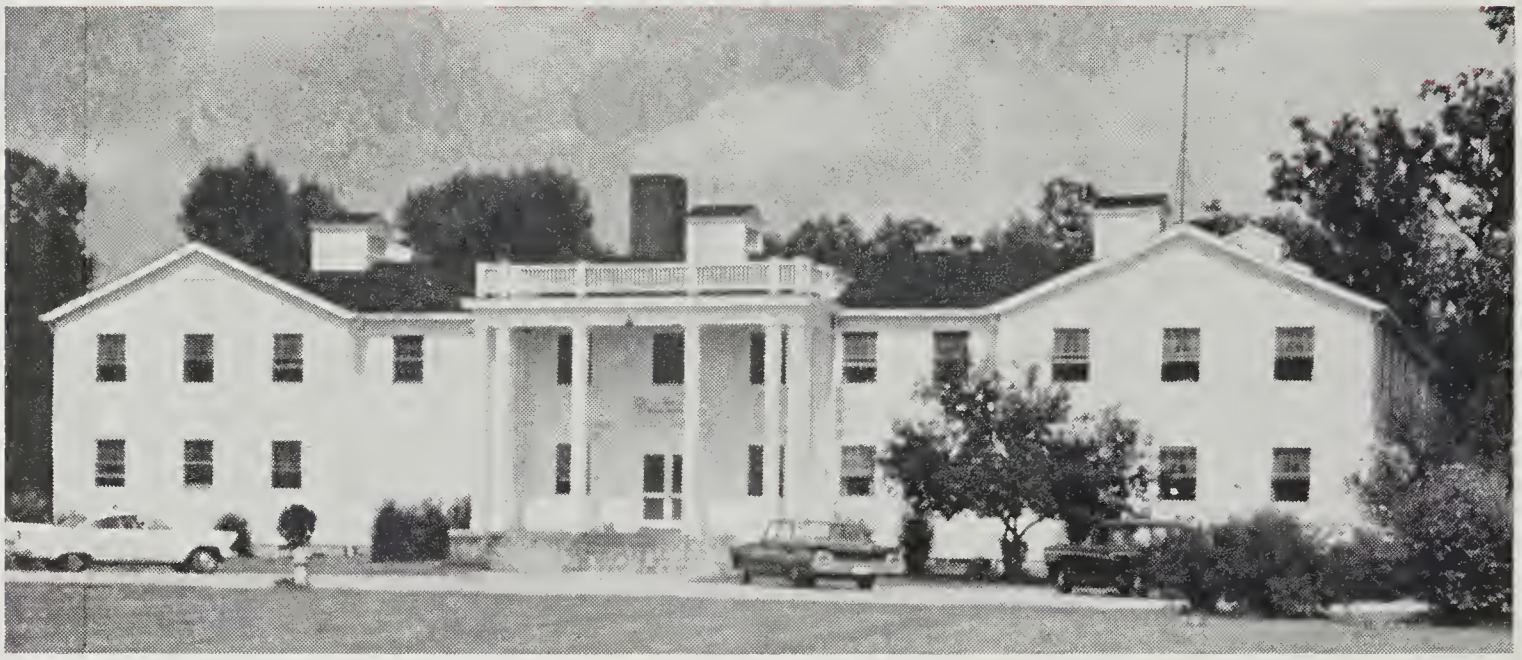
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehablilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 11 NUMBER 4

NOVEMBER-DECEMBER, 1961

RALEIGH, N. C.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: The NCARP regretfully announces that it has, at this time, become necessary to curtail **Inventory's** out-of-state mailing list. Out-of-state requests from **individuals** for a place on the mailing list can no longer be accepted. This new policy, however, will not affect those individuals who are presently receiving **Inventory.**

NEW HAVEN, CONN.: Dr. Selden Bacon, director of the Yale Center of Alcohol Studies, recently announced that the Center will be relocated at Rutgers University in New Brunswick, New Jersey. The transfer will be financed by a grant from the National Institute of Mental Health and will cover most of the costs of operations for the next six years. The move is expected to be completed by the spring of 1962, and the staff members of the Center will be added to the staff of Rutgers University. The Summer School of Alcohol Studies has been scheduled for July 1-26, 1962.

DURHAM, N. C.: The second of the Flynn Christian Fellowship Homes to be established in North Carolina was opened recently in Durham. A home for alcoholics who have just been released from prison or institutions, the facility will provide a place for persons to live until they have located a job and established themselves in the community. The Flynn homes are non-profit and non-denominational, and several dozen of them have been established along the East coast of the United States in recent years. One home is already in operation in Charlotte, N. C. and another is scheduled to be opened in Fayetteville.

RALEIGH, N. C.: North Carolina Governor Terry Sanford recently unveiled a two-pronged attack on the problems of alcoholism and crime in North Carolina. Cooperating with Alcoholics Anonymous groups, the State's prison and probation systems will attempt a rehabilitation program that is hoped will help alcoholics and save the State a great deal of incarceration costs. Under the plan, AA units will be set up in each prison unit to work with prisoners who have alcohol problems. In addition, judges will be encouraged to put more alcoholic offenders on probation. Probation officials will also work with AA in rehabilitation efforts. Extension of the program through probation would come first in larger communities, where there are fulltime probation personnel and adequate AA organizations. Convinced that too many alcoholics are being sent to prison, mostly for short terms, the Governor and State Prisons Director George Randall hope to stop these offenders short of incarceration through rehabilitation programs.

RALEIGH, N. C.: The NCARP and its governing body, the N. C. Hospitals Board of Control, sponsored exhibits at the State Fair this Fall. The theme of the Board of Control's exhibit was "Care and Treatment of the Mentally Ill", while the NCARP had as its theme, "Hope and Help for the Alcoholic."

CHICAGO, ILLINOIS: The annual meeting of the North American Association of Alcoholism Programs was held in Chicago November 5-9, 1961. One of the highlights of the meeting was a talk by Dr. Nevitt Sanford, general and scientific director of the Cooperative Commission on Alcoholism which has its headquarters at Stanford University. Dr. Sanford brought NAAAP members up-to-date on the activities of the Commission which will spend five years delving into every field of study relevant to the understanding and relief of alcoholism in the United States and Canada. In addition, the Executive Committee was empowered to continue negotiations for the establishment of a central office for the Association. Dr. Norbert L. Kelly, associate director of the NCARP and a second vice president of the NAAAP, attended the meeting. Bismarck, North Dakota will be the site of the 1962 meeting to be held in early October.

RALEIGH, N. C.: Approximately 125 AA members and professional personnel from all over the state who have participated in and supported the N. C. Prison Department's AA program during the past four years were entertained at a breakfast at the Governor's Mansion on November 5. In addressing the group, Governor Terry Sanford thanked those present for their participation and fully endorsed the prison AA program. He remarked that he was pleased with the wonderful results evidenced by the large number of inmates who attended prison AA meetings and who, after their release from prison, were continuing to lead sober and constructive lives through participating in community AA programs.

WINSTON-SALEM, N. C.: The Alcoholism Program of Forsyth County was host to the organizational meeting of the Alcoholism Praograms of North Carolina (APNC) at the Robert E. Lee Hotel November 17. The first officers of the APNC, elected after the a doption of by-laws, are: Marshall Abee, Winston-Salem, president; Worth Williams, Greensboro, vice president; George Adams, Raleigh, secretary-treasurer; and Bill Hales, Charlotte, member at large on the Executive Committee. Prior to the business session, Drs. Walter Sykes and George Thrasher discussed the expanded treatment program for alcoholics at Dorothea Dix Hospital in Raleigh.

AA MEMBERS: Alcoholics Anonymous recently reported that it now has 8,615 groups with a membership of 300,000 in 82 countries. The figures represent a gain over 1960 of 5 percent, or 404 in the number of groups. Membership is up 7 percent.

STOWE, VERMONT: Dr. Gordon Bell, director of the Bell Clinic in Willowdale, Ontario, Canada, told the Technical Assistance Project Conference on Alcohol Education that violent addiction may follow continued usage of some tranquilizers—especially those of the meprobamate group. He said that these tranquilizers could easily become habit-forming.

HILLSBORO, N. C. The Reverend W. Clark Porter has recently been elected chairman of the Orange County Council on Alcoholism. Other officers are Dr. John Ewing, vice chairman; Harold Webb, secretary, and Calvin Burch, treasurer.

Student Writes

As a student in Sociology, I am required to write a term paper concerning alcoholism. I would appreciate any material or information you could send me.

Nicky Herring
Roseboro, N. C.

Help For Ministers

Our Al-Anon Family Group intends to send one copy of "Alcoholics Are God's Children, Too" to every minister in our town. We hope this will help with the education of the public to the great need of better understanding of the problem of alcoholism. We thought the booklet wonderful.

Anonymous
Rapid City, South Dakota

Much in Demand

We have just about exhausted our supply of educational materials on alcoholism, and will appreciate it if you can replenish our stock. We particularly like the booklet, "New Cornerstones", for which we have had considerable demand.

Anne Tillinghast
Psychiatric Social Worker
Haywood County
Health Department
Waynesville, N. C.

Fine Magazine

I should like very much to have a dozen extra copies of the July-August *Inventory* for distribution. This is a fine magazine always, and this issue is, especially, because of the tremendously meaningful contribution by Bill W. called "The Language of the Heart."

Anonymous
Lumberton, N. C.

Highly Recommended

Under existing procedure in this county a member of this office attends the meetings of our county Mental Hygiene Commission.

It is noted that a considerable percentage of the patients appearing before the commission are charged with inebriety due to alcoholism. Your publication, *Inventory, has* been highly recommended by our county clerk, Mr. Paul Wehrle, and we would appreciate being placed on the mailing list to aid us in our official participation in this important function.

Charles M. Walker
Prosecuting Attorney
Kanawha County
Charleston, West Virginia

Inspiration to Sobriety

I think it's past time for me to write you and tell you how much I enjoy reading *Inventory.* It has been coming to me regularly for a long time now, and it is an inspiration to my sobriety.

I have been sober for 8 years and have 8 blue chips in A.A. I go to quite a few AA meetings here in Eastern North Carolina.

Kindest regards for the continued success of the NCARP.

Anonymous
Greenville, N. C.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

RELIGION IS RELEVANT to MENTAL HEALTH

 Its original title was Creation, Redemption, Sanctification, and Mental Health. The author is currently Chief of Chaplains, State Hospital No. 1 Fulton, Mo., where his responsibilities include pastoral care of patients, supervising clinical training, and research in the area of religion and mental health. An ordained minister of the Congregational Church, he has served twelve years as a parish pastor and two years as a Navy chaplain during World War II.

BY WILLIAM F. ROGERS, Ph.D.

MAN'S religious faith is an end in itself and not an instrument of mental health or any other secondary goal. Nevertheless, in our day when men are actively seeking ways of dealing with their frustrations, fears, and tensions, it is not amiss to recall that one of the by-products of religion is help in meeting the stresses of life. This paper attempts to deal with three basic tenets of religion which are relevant to this concern.

Creation, redemption and sanctification are three facets of religious life which speak to the mental health of man by giving him value, forgiveness and fulfillment.

The first concept of our faith which has significance for mental health is that of man's special creation. Regardless of the process, theologians conceive of man's origin as being the direct result of divine initiative. The Psalmist sang: "It is God who hath made us and we are His" (Psalms 100). In Psalms 8 we read that in spite of man's apparent insignificance in the overall scheme of things, he has a basic dignity which makes him a little less than the angels. The Genesis accounts state plainly that God made man in his own image. Man in his basic being has a value and a worth which remains constant in spite of all of the accidents and vagaries of life. This is the firm foundation on which man can build.

This is man's base from which he can face the problem of meaninglessness which Paul Tillich in *The Courage To Be* lists as one of the ontological causes of anxiety. If man can conceive of himself as of worth because of his creation, then he can take the further step of accepting the fact that what he is and does really matters. If basically what one is counts, then the multitude of activities in which he engages in an effort to fulfill himself also count. Furthermore, there is also meaning to the suffering and pain through which he must go as part of his earthly existence.

This meaning manifests itself in the terms of status. This is brought into sharp focus when we take the extreme situation of many of the patients whom we see in our psychiatric hospitals. They have been a failure in every way in which men seek to establish themselves as having status. They have failed economically. They are quite lacking in creative skills so that they can not win the plaudits of man by their achievements. They can not win beauty contests or athletic trophies. They have failed in their family and other relationships. They have been taken out of the normal activities of life by illness or handicap. They have lost the ability to handle themselves, and can not trust their own emotions or their own thought processes. Some of them have passed the prime of life and are experiencing the entrenchment of their powers without ever having tasted the fruits of success. We can well understand their feeling of despair. We can well ask with them: what do they have left? What is there to give life meaning and what have they with which to find status? The answer we are forced back to is the fact of man's creation and the basic dignity which is inherent in every man because of this. "It is God who hath made us and we are His." Because of this, man has a status which gives him stature no failure can erase.

This concept of creation in addition to giving meaning and status, also gives hope. Man is strengthened for the meeting of the here and now if he can visualize a fulfilling of his person and purposes in the future.

Man can carry on when he has within him the hope that tomorrow he can correct the mistakes of today or that the creative forces within him ultimately will be released. Religion says to man: you are creat-

ed in the image of God, and although this image is badly blurred by the dark forces operating within and the frustrations confronted w i t h o u t, nevertheless in the long run God's purpose can be fulfilled. This is a hope which has vitality as man seeks to fulfill himself here in this life. It is also a hope which makes this life more significant when one sees it as part of the larger purposes of God. Even though one may fail in the here and now to achieve the resolution of his dilemma, yet his striving

here will find its ultimate fulfillment in this eternity. Hope is justified in that tomorrow will see the fulfillment of today. It is doubly justified in that the hereafter will see the fulfillment of the now.

A second facet of religion which has relevance for mental health is redemption. Man's essential being—his created self—is good. His existential self—his ego as it has developed in his living out his sojourn here on earth is corrupt. As St. Paul put it, there was a war between his mind and his flesh. Theologians have called this original sin and they have dramatized its universality through the story of the fall. Freud explains it in terms of the libidinal instincts which set the individual against the demands of society. Jung sees it as part of the collective unconscious arising out of the negative experiences of past generations. Interpersonalists see it as the result of the bad experiences of infancy when, because of frustration and denial, love has turned to hate. However we analyze it or whatever we call it, two characteristics are involved. Man has a warring in his members which keeps him from releasing his creative efforts, and he is unable to be free and spontaneous in his relationships to his fellow men.

In the inner struggle he experiences there is a conflict which Sherrill in his book, *The Struggle of the Soul,* sets forth as an inner propulsion to fulfill one's individuality, on the one hand, and a shrinking back on the other. This is more, however,

than just fear of entering into a new experience. It is an inner barrier to even looking honestly at oneself because he is consumed in the inner conflict of the forces of darkness and light. Too often one does act. He does those things which he would not do and leaves undone those things which he would do. There is a bondage of the will which keeps men from exercising freedom in thought and word and deed.

At various levels this inner struggle produces migraine headaches, emotional exhaustion, and all kinds of physical and emotional symptoms. In the long run it leads to various types of neurotic behavior as one seeks to resolve the conflict or to control the anxieties which it produces. It may even lead to psychosis.

How is one to be freed from this body of death? Religion and psychiatry are agreed that the basic element in healing is love exemplified in a living relationship. For a Christian this love has its origin in God who so loved the world that He gave His Son who became incarnate in human flesh and lived and died among men. It operates through the beloved community and through the personal ministrations of consecrated individuals. It is a love which enfolds and supports us as we work out our own inner conflicts, and accepts us as we gradually permit ourselves the freedom of releasing our inner energies.

This love seeks not to fulfill its own needs, but is focused entirely on the needs of the beloved. It suffers long and is kind to the beloved as he struggles through the process of becoming a free person in his own right. This love never fails and it is taxed by the burden of the release of all kinds of aggressive and hurtful energies. This love accepts the beloved on the basis of what he might be even when the beloved can not accept himself. It permits the beloved to be a self in his own right, but it does not leave him to struggle alone. Henry Guntrip in *Psychotherapy and Religion* reports a dream of one of his patients in which the patient stands facing a dark cave—his own unconscious filled with evil creatures—but he is not afraid because Jesus is standing with him. In the support of this love, man can face his inner darkness, and come to grips with his own dark shadows.

A necessary part of redemption is the handling of guilt feelings in such a way as to permit one to be free to fulfill his own being. This means emancipation from the burden of past failures, together with an increasing ability to face the aggressive and unredeemed forces within. It means also an increasing security in one's relationship to others.

The Christian Procedure

The Christian procedure for handling guilt is through forgiveness which means the acceptance of the guilty in spite of his errors and his untamed libidinal drives. For the Christian this forgiveness is initiated by God, in that while we were yet sinners Christ died for us. This forgiveness is mediated to the recipient through its ministry and its blessed community. This is not a once and for all procedure, but is an ongoing process because one never reaches perfection. He is always in bondage to his inner nature which is only partially and progressively redeemed.

This forgiveness is continually offered to all men, but not all men accept it, and others only accept it part of the time. These men either are afraid to face the darkness of their unconscious even with the pressure of the forgiver, or they have found a pseudo-acceptance on a compromise basis which they are afraid to release for fear that the forgiver will not be

truly accepting after all. It is the nature of religion to accept erring humanity, but often it is difficult for the individual to accept the acceptance.

Redemption, moreover, is not just for men in moral extremity. All have sinned and come short of the glory of God. In other words, all have within themselves the neurotic rigidities which keep them from releasing all of their creative energies. Basic insecurity has led to the development of compromise patterns of behavior which use much of one's creative energies in finding pseudo-security. Day dreams take the place of achievement, and fantasies of power take the place of creative effort. Men sit on the sidelines and identify with the home run hitter and women read romantic literature to escape from their drab existence. Instead of entering creative relationships, men strive to gain the plaudits of their fellow men or create an inner world where the plaudits come at their bidding.

Redemptive religion reduces the need for this make believe by enabling the individual to accept himself as he is. By enabling him to deal with his hostilities and his guilts, it clears the way for him to relate on a more realistic basis. It helps him to fulfill his true selfhood, and thus it enables him to give himself to others. His recognition from others comes, then, from a real relationship rather than from secondary characteristic or achievement.

Another manifestation of this basic insecurity is modern man's striving for security in things. When men feel insecure in the love and acceptance of their fellow men, they seek to find it in the possession of goods. No matter how much one has he must strive for more. This afflicts the rich as well as the poor, and those in between. If we could just have a little more than we have then all would be well. But it never is.

A vast majority of men in the western world have enough acceptance from their fellow men plus enough success in the accumulation of goods to find something of an uneasy semi-security. When this combination breaks down, though, then they are in trouble. Unemployment or business failure undermines the accumulation of goods on the one hand or, on the other hand, conflict may destroy the feeling of acceptance so that the security of goods, even though substantial, is of itself inadequate.

A third facet of the religious life which speaks to the mental health of man is sanctification. This has to do with the creative use of man's released powers. When, by the grace of God, he has been redeemed, then he has energies to direct into the service of God and his fellow men. Men are no longer his enemies against whom he must fight or from whom he must run away.

We can illustrate this from an incident in the life of St. Paul (Acts 27). His active ministry ended with his imprisonment in Caesarea. Two years later when he was being transferred from there to Rome, the ship on which he was being carried was faced with shipwreck. The sailors, recognizing the danger they were in, sought to sneak off to save themselves even though the rest of the company might perish. The soldiers who had Paul and the other prisoners in charge wanted to kill them. In this way they could be sure of keeping the prisoners from escaping and becoming a threat to their own adequacy as guards. It was St. Paul, the redeemed, who was able to see the total group and to say, "We are all in this together; if we are to be saved, we must all act as a company and be saved together."

Another important part of the religious life is the ability of the individual to face the adversities of life. One of the great heresies of our day is that if one has faith he will be spared the ills of life. Great religion says not that the man of faith will be spared outward stress, but that he will have the inner resources with which to meet it. There is a story in the Old Testament (Daniel 3) which illustrates this. Shadrach, Meshach, and Abednego were three devout men of faith, who because of their loyalty to their beliefs were thrown into a furnace, heated so hot the author says, that the men who threw them in were overcome by the heat. Nevertheless, when the king who sentenced them had the furnace opened he saw the men walking in the flames unharmed and with them was a fourth presence like unto the divine. Men of faith aren't spared the pain of suffering but when they go through it they have the resources of the universe on their side.

Again the classic illustration of this is St. Paul who showed great power in the face of all kinds of adversity. He was physically ill, he was beaten with the lash and with rods, he was stoned and left for dead, he was in peril in his travels, having, among other things, been in shipwrecks three times, he was often hungry and without drink, he was bitterly opposed in his work, and dissension wracked the churches he had founded. Much of his creative work was done while he languished behind prison bars. Nevertheless, he demonstrated great creative powers in the service of the Christian faith. His inner man had been sufficiently freed from conflict for him to live a creative life in spite of the outer conflict which was great.

Dr. Stafford Clark in his chapter, "The Nature of the Problem," in *Christian Essays in Psychiatry,* states that one of man's basic needs is to believe. Man has to behave as if what he does really matters. He cannot accept meaninglessness as the foundation of his existence.

However, the adult in modern society often finds it difficult to find meaning in his existence. His struggle for inner fulfillment and outer acceptance are often thwarted by his own inner conflicts and anxieties. He is a stranger in a strange land trying desperately to find security and status and a feeling of worth.

To this modern man, religion says that there is meaning in life because back of it all is a creator—God—who in holy love creates, sustains, and orders all things. Man—each man—is a part of the purposes of God. God knows that this good creation of His has been corrupted by his earthly sojourn, but His love doesn't fail. This divine love, mediated often through the redeemed community, is sufficient to allow man to look at himself and to bring into the light these dark inner shadows that they may be illuminated and dissipated. Once redeemed, man is called of God to use his new creative powers—his new ability to love—in service of his fellow men. Religion is not a creed or an ethic or an organization; it is the love of the Living God redeeming man and setting him free for greater works. Modern man can be like the prophet Isaiah who in time of disaster went into the temple and confronted the Living God. In the Holy Presence he saw himself and cried, "Woe is me for I am a man of unclean lips and I dwell in the midst of a people of u n c l e a n lips." Thereupon a heavenly messenger took a coal from off the altar and laid it on his lips and cleansed them. Then God said; "Whom shall we send? Who will go for us?" Isaiah said, "Here am I, send me," and Isaiah went out to be a prophet of the Lord (Isaiah 6:1-8).

• *An AA member recommends both group and individual inventory.*

I hope I'll never forget the evening I came home after about the third or fourth AA meeting I had attended. I was carrying in my mind's eye and in my heart a picture of these new people I had met. They had said, "We are not saints . . ." yet their words and, more important, their activities seemed to belie that statement. The warmth and love, the out-stretched hand of our Fellowship was a moving experience for me. I was on cloud nine and searching for a way to describe these remarkable people to my good mate who was awaiting me with tongue in cheek and cynical eye.

"They are like nothing you've ever met before," I said, enthralled. "They are like saints, but their halos are at a jaunty angle, like a song-and-dance man's straw hat."

My feelings might not be expressed by others in exactly these terms, but they are not uncommon in our Fellowship, particularly when we are new on the program. Time has not disproved this first glow. Although we have our share of failure, alcoholic death, tragedy, phony people, odd-balls (who am I to talk?) and the usual cross section one finds in human society, time has served to strengthen and mature my conviction of the essential greatness of our program. It has enabled me to watch the growth, the flowering of character and the goodness in a large number of my fellow AAs.

It is my belief that we are fortunate enough to be an important working part of a great step forward in mankind's progress toward a better world. This continued evolution of man is not put forth by me as a thesis. Nearly every scholarly author on the subject will state that, although man may have developed to his optimum physically, he is still evolving mentally. And some include the concept of the evolution of the spirit. I recently saw an interesting design on the paper jacket of a popular anthropology book. It pictured a hunched ape-man trailing after a handsome specimen of modern man, who, in turn, was following a creature robed in white, with wings and halo. Without opening the text, the author's main treatise is clear: Evolution has not come to a standstill; mankind has not yet arrived; his

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growth capacity is enormous. He can, in the future, become a being as far removed from modern man as he presently is from his ape-like ancestors (providing he doesn't blow himself off this good green planet first).

I know that we AAs are not unique, and decry any statement that sets us apart from other men and women. As one of my friends says, "Alcoholics are just like anybody else, *only more so.*"

We do not have a corner on the market where man's emerging mind is being developed. However, I do not think it presumptuous to regard our AA program as one of the major world-wide steps into that dim possible future where man can live a better life, at peace with himself and his fellows.

As a solution to a health problem alone, our program deserves to rank along with the great medical milestones—the work of Pasteur, Mme. Curie, Dr. Salk and others. Don't take my word for it. Read the telegrams sent to our Twentieth and Twenty-Fifth Conventions by Dwight D. Eisenhower.

We have members who have risen to great moral and ethical heights in their life on our program. We can point to people who, though nameless, have shown a selfless devotion to the principles of AA and to the sick alcoholic which, in any other endeavor, would put them in the newspapers. In my own experience, I have seen two fine people die of cancer. They did not drink, nor did they complain. They continued their AA work to the end and, even when forced to bed, were a shining example to others. I have known people doubly afflicted—with alcoholism and with concommitant ailments such as blindness, multiple sclerosis and diabetes. They have shown courage and faith in the face of almost insurmountable obstacles that are beyond the power of words to describe. I do not cite these examples to bolster an argument; they are plain facts concerning real people in AA. That they are not statistically valid in any sense, I am aware, but you and I know that they are typical examples of the many beacons of hope that successful members of AA have presented to their fellows and the public at large. They can probably be duplicated a hundredfold in AA around the world.

"Yes," you will say, "but the majority of us AAs are simple souls who pursue our daily living without achieving such valiant nobility."

From Two to 300,000

True, but we must never underestimate the potential of any man. Drunk, we were a deadly menace on the highway, a burdensome invalid in the home and an embarrassing social problem, a drain on the taxpayers (etc. ad nauseam). The mere fact that we are sober and in fair to excellent health is a great step forward. Add to this the fact that as an aggregate we have climbed from two sober alcoholics twenty-six years ago to the estimated 300,000 today, and a glimmering of group potential can be envisioned. It is axiomatic to our sobriety that in order to maintain it at all we must progress in the areas of moral and ethical values.

How truly precious is our AA heritage; how pregnant with meaning for the future! If it is true that many of us, either as individuals or as groups, are capable of what the foregoing implies, we have a great obligation and duty to fulfill. There are many pitfalls along the way.

As a sterling example of the AA member who is loaded with and struggling against many character defects, I feel I can safely voice our needs of a constant running inventory, both group and individual.

Where can we start this inventory? What are some of the areas we should examine and strive to remedy, cut out or improve? How can we best rededicate our lives to the service of the sick alcoholic? To deal with these questions thoroughly in this article is impossible. Whole books have been written to aid us in living up to our Steps and Traditions. But perhaps you and I can get a start toward re-evaluating a few critical areas in our AA life together.

1. *We must not rest on our oars*

We have been reminded time and again in recent years, by talks and in reading, that we have barely scratched the surface of the alcoholic problem. We have been told that our first quarter-century is but a beginning and that the future holds great challenge for us all. We have been warned against complacency and against subscribing to the policy that having accomplished a great deal, we can relax and coast along. The warning is well taken. For example: Dr. Hodel, lately connected with our State Hospital, estimated that there are 12,000 alcoholics in Hawaii. Only a few hundred are attending AA meetings. Statistics on a national scale are even more imposing than these. We must tirelessly carry the message to the suffering alcoholic.

2. *New horizons*

AA is in the unique position of being a tremendously respected organization in the world today. What we say and how we act are regarded with lively and sincere interest. People look to us and our leaders for some of the answers to the baffling problem of alcoholism. People seek our advice and recommendations. The threshold we cross today extends our influence into the areas of public health, legislation of public funds, education, institutional administration, industry, medicine, psychiatry and social work. AA as such does not enter these fields, but we as individuals are being called on more and more in an advisory capacity. However, people tend to judge an organization on the performance of its individual members. This is not fair, but we have to live with it. If we are to protect the good name of AA we must ever be aware of our Steps and Traditions when venturing into public service.

3. *Our shield of anonymity*

Our Twelfth Tradition becomes all the more meaningful as the demand for our services grows. We were told many years ago that just one of us drunk at the level of press, TV and films would cause untold damage. Most of us took this to heart and abided by a self-enforced anonymity. A look at some who broke anonymity at the public level has justified this advice. These occasions have not only been sad but they quite take the force out of our potential to help the sick alcoholic. If we are to pledge our lives to the future of AA as suggested at the Twenty-Fifth Convention, we must guard against our typical character weaknesses such as egotism, vanity and power-hunger.

Rumblings of conflict between groups and individuals in AA at a public level reach our ears from time to time. Temper tantrums and wild emotions inflict themselves on the scene where steps are being taken to establish alcoholic service centers, clinics and the like. Some of these are inevitable and are classifiable as good normal growing pains. But some are excessive and reach ears not geared to understand our own brand of "alcoholic thinking." Let us remember that there are no "wheels" or "big shots" in AA. "Our leaders are but trusted servants . . ." Are we living up to that trust?

4. *Working with professionals*

Let us seek to meet with true humility those who sincerely want

to help our people: the psychiatrist, the doctor, the prison warden, the clergy, the skid-row mission leader, the alcoholic committees and our political leaders. To be sure, their approach may not be "right." All the more reason for us to hold our tempers and take up the burden of working closely with them in an effort to close the gap between our misunderstandings. Let us also remember that we do not necessarily know all the answers. Some of these people have made a study of our problems and have much to contribute in the way of constructive advice and help.

I always get cold chills whenever some blatant statement like this comes out: "I don't believe in doctors or psychiatrists! I got sober on AA alone. If I can do it, anybody can do it."

Heaven help the pigeon who falls into this man's hands! We may end up attending a funeral. If we read the Big Book and any AA literature, we will find that a thorough physical check-up by a competent physician is recommended for *all* new AA people. If the doctors in a community are not educated AA-wise, isn't it our duty to see that they get our books and literature so they can do a good job for our people?

These are only a few starting points for a group or individual inventory, but I believe they are vital to our survival and to the future of AA. The late Peter Marshall has said that we should not worry so much about our personal *rights,* but should be more concerned about our *duties* and *responsibilities.* If we can succeed in this, we can be assured of making a significant contribution to mankind's progress. And we can be reasonably certain of fulfilling our destiny—the maintenance of our own sobriety and the gentle leading of our sick ones, with God's help, out of the valley of the shadow into the light of hope.

ARC HAS NEW STAFF MEMBER

Guy T. Elliott, Jr. joined the staff of the N. C. Alcoholic Rehabilitation Center October 1, 1961 as admitting officer and chaplain.

A native of Kinston, Elliott came to the Center from Fayetteville where he was employed as a counselor with the Employment Security Commission. He is also the pastor of two "half-time" churches in Jones County.

Elliott attended the University of North Carolina and graduated from Atlantic Christian College in 1951 with a dual major in social science and religion. Following graduation, he was ordained in the Christian Church and entered the College of the Bible, Lexington, Ky. from which he graduated in 1955. From 1949-1955 he served as a student pastor in North Carolina, Kentucky and Indiana.

After serving churches in Albany, Ga. and St. Petersburg, Fla. as pastor and associate pastor, respectively, he returned to North Carolina to work on his master's degree in psychology which he earned from East Carolina College in 1960. He has also worked as an interviewer with the E. S. C., a V. D. investigator in a county health department, and sold insurance.

An "out-door-man", Elliott's favorite "participating" sports are hunting and fishing. His favorite "spectator" sport is football.

CHRISTMAS
IS A
THOUSAND
THINGS

IT'S A WINTER'S NIGHT, AND
AN ANGEL SONG . . .
A GIANT STAR, AND A TINY
STABLE . . .
A MANGER, AND STRAW, AND
SWADDLING CLOTHES.
CHRISTMAS IS A CHIME . . .
A BOY SOPRANO, AND SILENT NIGHT . . .
CAROLERS, AND THE FIRST NOEL . . .
THE TINKLE OF A BELL ON A SLEIGH . . .
OF A COIN IN A CUP.

CHRISTMAS IS DICKENS, AND SCROOGE,
AND TINY TIM . . .
IT'S HOLLY ON THE DOOR, A CANDLE IN
THE WINDOW . . .
THE SCENT OF PINE, AND THE SPARKLE OF
TINSEL.

CHRISTMAS IS RED AND GREEN . . .
AND BLUE AND SILVER.

CHRISTMAS IS WHITE.

CHRISTMAS IS CARDS, AND RIBBON, AND TISSUE
PAPER . . .
IT'S A TRIP HOME, AN OPEN LATCH, AND A
HANDCLASP . . .
IT'S GIBLETS AND BISCUITS . . .
CRANBERRIES, AND MINCEMEAT PIE.

—FROM **NEW HOPE**

A publication of the Leavenworth, Kansas Penitentiary AA group

Merry Christmas...
ARP Staff

A minister cites reasons why the Church should be concerned about the alcoholic and proposes a plan of action including four points.

I would like to begin my discussion of *The Church and the Challenge of Alcoholism* with this question: What does it mean that the most significant events in the field of alcoholism in the last twenty years, and even before that, have occurred outside the Church?

Dr. William Menninger was out in Los Angeles recently and made the statement that more people suffer from the illness of alcoholism than from any other mental or emotional illness. It is striking to realize that if all of the people with alcoholism in the United States were together in one place, they would constitute a city larger than Chicago by about a million. I flew over Chicago a little while ago, at night. The beautiful panorama of lights was spread out below me and I thought about this fact of alcoholism as we came in over that giant metropolis.

Alcoholism can be very simply defined. An alcoholic is a person who has lost, or is in the process of losing, his *ability* to control his drinking. The usual places where you see this loss of control are in his interpersonal relationships. That is, his

CHURCH & CHALLENGE OF OHOLISM

Y DR. HOWARD J. CLINEBELL

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drinking is influencing adversely his family life, personal life, job life or his spiritual life.

Alcoholism, of course, is a festering sore in the body of our society. I spent some time, when I was in New York on the Bowery, on Skid Row and I was impressed by the fact that here was a symbol of the Church's neglect of a certain kind of alcoholic. The homeless-man alcoholic probably constitutes a little less than ten percent of the total alcoholic population.

I remember walking up and down the Bowery in old clothes and in an unshaven condition in order to be able to communicate with the men there. I gave a cigarette to a merchant seaman who was there on the Bowery in a drunken condition. He said to me after we got acquainted, "Slim, I hope you don't hit this street like I hit it." I think of this man when I meet anybody who believes that people are on Skid Row necessarily because they want to be there. Just this man, the tragedy, the pathos of his statement keeps coming back to my mind.

I have often asked myself this question when I have been near the

Skid Rows of our cities, (and any city of 25,000 or larger has a Skid Row), the streets of forgotten men: "If Christ were walking among us today, where would he more likely be—in a comfortable suburban church with padded pews or walking on one of these streets with these derelicts, this debris of society?"

The typical alcoholic is not the Skid Row derelict. He is your neighbor! I mean that he is a person like your neighbor and that you probably don't even know he is an alcoholic. He is still holding his job and living with his family. However, he is becoming increasingly dependent on alcohol. He is what has been called in literature the "hidden alcoholic." His problem is hidden from other people in a dark closet of fear and suspicion and desperation. It may, and this is even more serious, be hidden from himself so that he doesn't recognize the nature of his problem. The typical alcoholic is the hidden alcoholic.

Now why should the Church be concerned about the alcoholic? We are still struggling, aren't we, as churchmen, with trying to define what our job is in relationship to the alcoholic? Of one thing we can be completely sure—we *have* a job although we haven't been able to define it adequately as yet. Here are some reasons why we should be concerned: First, I think of the words of our Lord, how he came to proclaim the release of the captives. I think about this in terms of the four and a quarter million men and three-quarters of a million women who are captives of this illness. Second, the Christian has an inescapable concern for any child of God who is suffering. Alcoholics *are God's children* and none of us can begin to imagine the gigantic load of raw pain which their illness causes. Like the man beside the Jericho Road we are "neighbor" to the alcoholic. The third reason we in the church should be concerned is because we have a *unique contribution* to make to the solution of this vast problem!

Let me suggest four things that we in the Church can do about alcoholism. *First, education*: The Church has the widest educational entree and the largest face to face contact of any institution in our society. We know that there are over a 100 million people now in churches. There are about three million teachers who teach in our church schools. These facts mean that the Church has an unrivalled opportunity to help build the foundation of enlightened understanding about the problem of alcoholism without which any approach to either prevention or treatment will not be fully effective.

For example, I can't remember ever preaching a sermon or giving a public talk in which I mentioned the modern scientific approach to alcoholism when at least one person didn't come up afterwards and say, "I wonder, Pastor, if I could talk with you about my neighbor", or something similar.

Those of us who happen to be ministers are in a strategic position to bring the hidden alcoholic out of hiding by what we say in our educational messages about alcohol. I agree completely with Dr. Waldo Beach of Duke Divinity School who defines Christian love as the ability to read statistics with compassion. I think we need to personalize these statistics, to think in terms of the one among us who can really visualize or comprehend what five million alcoholics mean. (I think of it in terms of people who cross the threshold of our Pastoral Counseling Center almost every week whose lives are being destroyed by this illness.)

First of all, then, is education. We can help to build a solid foundation under the approaches which can be

made to the problem in the church and in the community.

And, secondly, I believe that the Church's job is *to be a leaven in the life of its community,* a positive influence for good. We can do a great deal, much more than we are doing, in what might be described as community outreach. May I give you some examples of what various churches are doing in this respect?

I was on a plane awhile ago on my way to a school of alcoholism studies in North Dakota. On the plane I sat beside a Baptist layman from Washington. He asked me where I was going and when I told him he responded, "I know something about AA; there is a group that meets in my church basement."

Powerful Impact

Now this fellow was feeling an indirect, subtle, but very powerful educational impact of getting acquainted with AA. I think if I were back in the pastorate, one of the first things I would do with my Church School teachers would be to encourage them to attend an open meeting of Alcoholics Anonymous and a meeting of the Al-Anon family groups. I would encourage them to do it before they tackled another unit on alcohol problems. Allowing AA and Al-Anon groups to use church facilities is almost always a mutually enriching experience.

Churches and concerned Christians, laymen and ministers alike, can work to achieve worthy community objectives. In 1958, almost 50% of the 3,000 plus general hospitals in our country would not admit alcoholics *as alcoholics.* This seems discouraging but if you consider the trend, it is really quite encouraging. Approximately a decade ago the figure was but half this number. At that time only a fourth of all the general hospitals in the country were admitting alcoholics and less than fifteen years ago there were fewer than a hundred hospitals who admitted alcoholics. Christians in many places are working to change the policies of their community hospitals in this regard. They are also helping by *using* local facilities and giving moral support to developing and continuing state programs and local committees on alcoholism.

Alcoholics Anonymous was taken to the whole Saint Louis area by a Catholic priest who took two of his alcoholic parishioners up to Chicago to attend a meeting. Several of the local committees on alcoholism have been sparked in their inception by concerned ministers. Second, then, is community outreach: We need to do much more in leavening our communities than we do.

Thirdly, is the *area of prevention.* How many members are there in Alcoholics Anonymous, this wonderful movement we have available today as a referral resource? There are about 250 or 300 thousand. Now between the years 1940 and the present, do you know how many new alcoholics were either created or discovered every year? There were about 140 thousand new alcoholics each year for that period of time. This means that a group larger than a third of the total present membership of Alcoholics Anonymous is being created or developed each year.

Prevention is one of the Church's key jobs. One reason we have not done as much as we could in the past is because we have had too narrow a conception of what constitutes prevention. Let me suggest that prevention can and should occur on at least three different levels.

First, prevention should occur through *early treatment.* When you catch an alcoholic before he reaches the final stages of his illness, you have prevented the most destructive

aspects of his illness. The average age in Alcoholics Anonymous has been declining every year since its formation and this is encouraging. We should know the early signs of the sickness of alcoholism. Sometimes this is like that sign on a country road which read, "When this sign is under water, the road is impassable." This is often the way it is with the signs of alcoholism so far as the alcoholic himself is concerned, but the point is that the family or the minister who knows these early signs can help to encourage early treatment.

The second level of prevention is on the level of *symptom selection.* Among Jewish people who abstain less frequently than either Roman Catholics or Protestants, there is less alcoholism than among either of the other two groups. The reason, I think, is not because of the attitude about drinking, but the attitude about drunkenness. An Orthodox Jew will usually drink, ritually or otherwise, but he almost never becomes intoxicated because his group has strong, unified sanctions against drunkenness. He may be very sick psychologically but chances are he won't become an alcoholic.

This is prevention on the symptom level, you see; he selects another symptom if he is sick, not consciously but unconsciously. Abstinence is a very effective way of preventing alcoholism on the symptom level. If all the abstainers, all the 40 million people who don't drink, started to drink today, we would have about two million eight hundred thousand new alcoholics in ten to fifteen years. (This is assuming that the proportion of drinkers to alcoholics remained constant for this group.)

The third level of prevention is *prevention at the grass roots.* We are concerned much more with wholeness of personality than we are about keeping people from drinking. We know that alcohol is chemically in the general category of ether and chloroform; it's a pain killer. And the reason why people drink basically is because they hurt inside—because they are anxious. We live in a world where many people are like Camus' "stranger"—wandering in a strange land—without a knowledge of the language and with no possibility of learning it. We live in a world of walls, walls for many people without windows, and alcohol provides a little window for the moment into the world of other people.

Whenever we stop to realize that the main reason the alcoholic drinks is because of this anxiety—that toothache-like pain in his soul—perhaps this does more than anything else to help us be compassionate rather than condemning toward the alcoholic.

Or take prevention at the grass roots so far as the spiritual side of things is concerned: For millions of people alcohol provides a pseudo-religious experience. This has been said in many ways. I think it is important for us to understand its relevance for preventing alcoholism at the grass roots. The founder of Alcoholics Anonymous said on one occasion, "Before AA we were trying to drink God out of the bottle." Those of you who are familiar with Greek mythology will recall that the only God of the after life was also the God of wine, Bacchus—the God of the transcendant ecstasy. Again you will remember that William James in his Gifford lectures, *Varieties of Religious Experience,* pointed out that there is a dynamic connection between the mystical consciousness of the religious man and certain stages of drunkenness.

What I am saying is that when religion loses its vitality, when it

loses its spine-tingling quality, when it loses its lift, then many people turn to a pseudo-religious experience in the bottle. To the extent that we are able to provide a man with the basic feeling of religious meaning in life, we help to prevent him from becoming an alcoholic.

The fourth main area in which the church can do something about alcoholism is that of *pastoral care of the alcoholic and his family.* Churches and individual Christians need to be involved in the rehabilitation of alcoholics. Why? It's not adequate to say, "Let AA do it", or "Let the local alcoholism committee do it." They have their important functions but they can't do it all. A study was made of a town in Ontario, Canada which had a number of very effective AA groups and a local clinic for alcoholics. What percentage of all the alcoholics were actually in treatment in this optimum setting? Seven percent. Alcoholism is a complex disease. We need all the approaches that we can get including the approach of pastoral counseling and pastoral care.

I think that the Church should be involved in rehabilitation for the sake of its own soul. I have a feeling the Priest and the Levite who walked by on the other side of Jericho Road were poorer spiritually for having done so.

As Christians in a comfortable society, we need to face up to the festering wound of alcoholism in a direct and firsthand way. We become so conventional, so respectable, and so irrelevant. It is my feeling that failing with the alcoholic, if you will —and again and again you will fail— is good for us. For one thing, it reminds us of the complexity of human tragedy and we need to be reminded of this. For another, it confronts us with the utter inadequacy of depending on our own cleverness, and with our need to depend on God, as we try to help others.

I think that the Church needs to be involved in rehabilitation because it has a unique opportunity and a healing mission. People *do* come to the Church for help. A recent study reported in *Americans View Their Mental Health,* (Basic Books, 1960), revealed that of all the people who have gone for professional help with personal problems, 42% chose their ministers as the person to whom to go. We do have alcoholics come to us and it is not a question of whether we are going to counsel with them. It is a question of whether we are going to do it poorly or well.

Redemptive Therapy

The Church is in a strategic position to help alcoholics because to a limited degree, at least, the redemptive fellowship is available within its organization as a healing resource. I know of no other group in society, except Alcoholics Anonymous, that is available week in, week out, year after year, as a kind of supportive, redemptive therapy. This is an important aspect of the Church's ministry. Alcoholics Anonymous is the most hopeful approach to alcoholism ever devised. I remember what Paul Tillich said when he attended his first AA meeting: "This is what the early church did." I say that AA is a judgement on the Church. Isn't it because we left a vacuum in our ministry that this movement arose outside the Church?

What can the Church do? First, we can be informed. We can accept alcoholism as an illness.

Many people are afraid of accepting alcoholism as an illness, in spite of the fact that the American Medical Association has so described it, because they are afraid that they will deny the elements of sin and responsibility by doing so. May I re-

assure you at this point as follows: When we accept the fact that alcoholism is an illness, we simply redefine the ethical problem in alcoholism. Certainly there is sin involved in the sickness of alcoholism. Whether you define sin as alienation from God and self and others, or as the misuse of a degree of freedom that we possess, certainly the alcoholic misuses the freedom that he has, like all the rest of us.

We need to learn to help the alcoholic and the family of the alcoholic. Perhaps in the Church we need to try something fresh. Let me give you an example of what one denomination is doing.

The Church of the Brethren has the most creative experiment in helping alcoholics that I have heard. It consists of having local congregations sponsor homeless alcoholics who are released from mental hospitals and have no place to go, just as many churches have sponsored refugee families. The National Board of the denomination prepares the congregation and helps them find an alcoholic. The first alcoholic that was sponsored by a congregation had four slips in as many years, but since then he had enjoyed eight years of sobriety. That one church has sponsored eleven other alcoholics in the intervening years. You can imagine the educational impact on that congregation of this first-hand encounter with this problem.

Let us turn now to the problem of making our personal contacts with alcoholics as constructive as possible. I think that more important than knowing about the techniques of helping alcoholics is what I would describe as the *therapeutic attitude*. I think it has to do with your feeling about alcoholics. If you see yourself *in* the alcoholic, then I think you are ready to work with alcoholics.

A retired minister, Dr. Harold W. Ruopp, describes his ministry in three stages:

"In the first stage," he said, "I tried to stand outside the life process. I was a spectator of the passing show, rather than a participator in a mighty adventure.

To use an analogy, I sat on the bank of a river and preached sermons of comfort and courage to the swimmers. I told them which way the current was flowing, where I thought the ocean was and what they ought to do when the current got rough. In the second stage a few years later, I became the great helper—sometimes even a savior—and humbly proud of my role! From time to time I jumped off the riverbank and put my arm around someone who was going down for the third time. I would get him straightened out with reference to the flow of the current, and then I would return to my place on the bank to wait for the next person to go down.

Then, a number of years ago, because of circumstances beyond my control, came a third stage. Now I am in the river all the time. I am not always trying to hold someone else up; instead, I gladly permit another person to hold me up. I ask others to tell me which way the current flows and where the ocean is. I am no longer the savior. Now I am the one who needs saving."

"Over and over again the humblest person in the humblest place has had his arm under me, even as my arm was around him. In the admission of great weakness I found great strength. In the willingness to be helped I became a better helper."

This is what I would describe as the "therapeutic attitude" which seems to me to be the basis of working with *anyone* who is deeply troubled, as the alcoholic and his family inevitably are.

THE first time Sally got drunk, she was five years old.

She lived on a plantation and one hot summer afternoon she disappeared. Her frantic parents recruited everyone on the plantation for the search. They found Sally under the cistern with the keg of muscadine wine—passed out cold.

Her parents thought it was hilariously funny at the time. If you only could have seen her, lying there with the sweetest smile on her little face, positively reeking of alcohol!

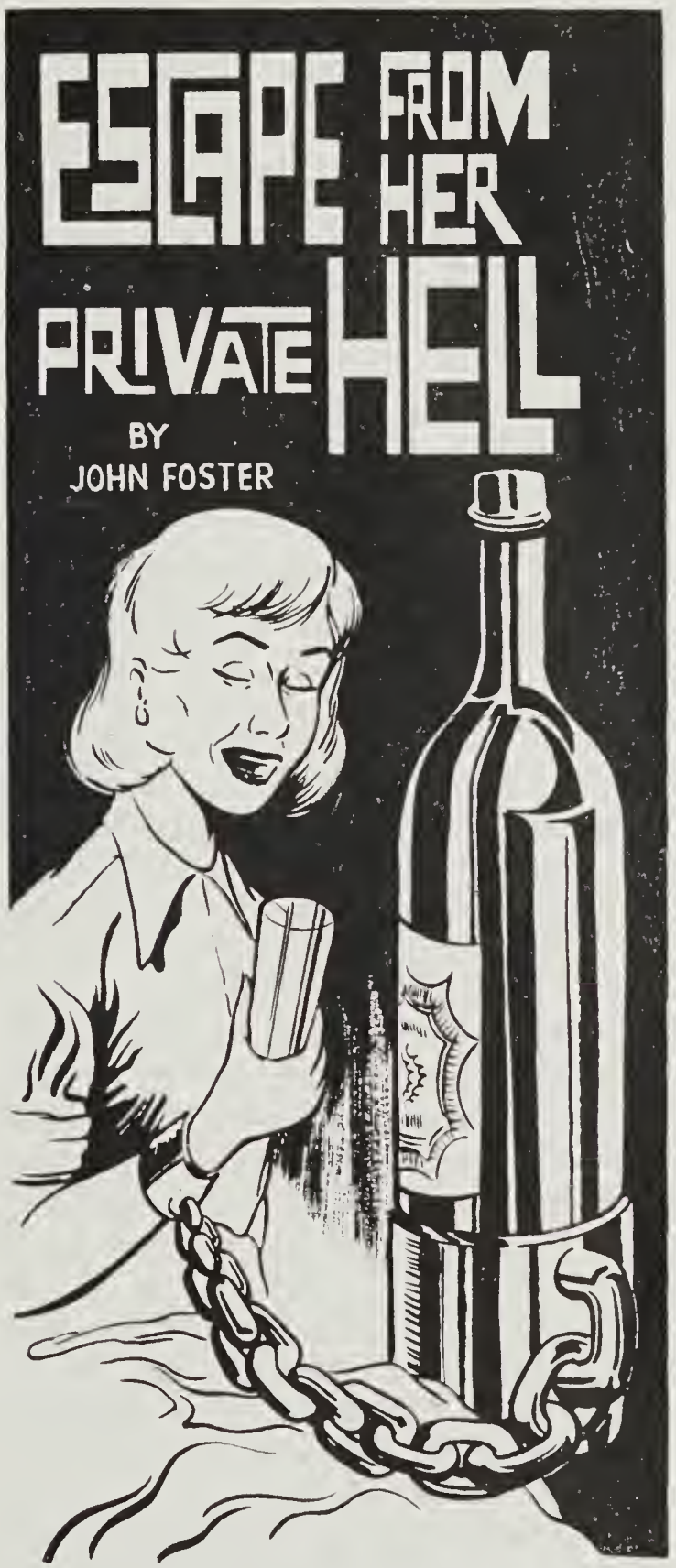
Sally remembered this years later during the mornings she spent vomiting her eye-opener drinks into the commode.

The second time Sally got drunk she was eighteen. It was a bitter-cold winter day and she was fox-hunting with her father and several other men, one of whom had a bottle. When her father wasn't around, Sally kept taking swigs until she was staggering. She sprawled across the back seat of a car and went to sleep. Her father, a deacon in his church, found her there and gave her a violent tongue-lashing, but he kept the incident from her mother who was still talking about the time little Sally had found the wine keg.

Sally is not the woman's real name, but every other detail of this story is true. She was one of the first women to make use of the facilities which the Committee on Alcoholism for Greater New Orleans offers both in the city and at Mandeville.

Sally now is an arrested case (alcoholism is an incurable disease) and is living as a housewife and mother in New Orleans. To the casual observer, her life does not appear much different from the way it was before. But now it's happy instead of hell.

She hopes her story will reach some of the nation's five million al-



Sally had no control over her drinking from the first time she got drunk at the age of five until she sought help and came to realize that she was an alcoholic.

coholics (about 30,000 of whom—including about 7,000 women—are in the Greater New Orleans area).

Shortly after the foxhunting episode Sally got married. Her husband was the man who had the bottle at the hunt. After the wedding he told her, "I'm going to teach you how to drink."

"He tried it every night," Sally says today. "It always ended the same way—with both of us passed out."

After eight months of this, Sally, realizing she wasn't getting anywhere, divorced him. But she continued to drink, which is to say, get drunk. For, no matter how she fought it, as soon as she took one drink, she was overwhelmed by the compulsion to keep on until she could drink no more, i.e. passed out.

Wrong Idea

Like many people, she wrongly associated alcoholism only with the "bum in the gutter," or the skid-row type alcoholic who makes up less than ten per cent of the total alcoholic population. She had never been in jail or been arrested for drunk driving (when she got drunk she didn't drive), so she did not think she was an alcoholic. She thought she was going crazy.

Along came World War II. Now Sally had always loved flying. When she was twelve, she and a boy across the road had formed a blood pact that they would both learn to fly. They had built a glider and dragged it behind a car for miles, trying unsuccessfully to get it up.

The boy became a fighter pilot and was killed in the final days of the war. Sally got her private license and went to work as an aircraft inspector. This was an exacting job in which many lives depended upon her judgment.

She was careful that this judgment was unclouded by alcohol.

She would go for months without a drink, and she never drank on the job. But eventually she would go on a binge. During a critical period of the war she alternated sixteen-hour and twelve-hour days for two weeks, trying to get 300 desperately needed planes into the air.

She and her fellow workers did get those planes into the air. Afterward, Sally went to Hot Springs, Ark., for a rest. She bought a half pint of bourbon, determined that she would drink no more. She kept buying half pints.

By the third day she couldn't hold any food down. By the fourth morning she couldn't hold any whiskey down, but she kept trying. She would down a shot and vomit, then down another and another until eventually one would stay down and she would begin to feel herself coming back together again.

"Then," she says, "I took those baths and boiled it all out of me."

On parties and dates she would have a good time—during the early part of the evening, you understand. Towards the end of the war she started having blackouts. She would remember everything up to a certain point. Then nothing.

After the war, still hoping that her love for flying might help her, she took a job as aircraft inspector at Hickman Field in Honolulu. This was a "geographic cure." Once there she wouldn't drink at all. Positively. But she wasn't there yet.

In San Francisco before her ship sailed, she holed up in a hotel and pitched a good one. She was a very strong-willed person in most things, and she was still determined to limit her drinking. She would buy one pint and that would be all.

By the fifth day she had a truly impressive array of bottles in her dresser drawer. She also had a $100

phone bill from calling her sister long distance to tell her goodbye.

In Honolulu she stayed dry for six weeks, and then she met a very cute boy. She was going to be very ladylike and just have a martini or two. Both she and the boy ended up drunk. At two a.m. they found themselves at Waikiki Beach.

"It would be nice to go swimming," she remarked. "You can't go swimming without a bathing suit," he said.

"Hell I can't," she said, and plunged into the surf with her clothes on.

A short while later Sally and the boy got married, and after two years in Hawaii they returned to the States, settling in New Orleans. Sally would stay dry for months, but sooner or later she would have that first drink. She took it straight because she was convinced that it was the mix that was making her sick.

Many times when her husband came home she would be drunk and he wouldn't know it. In the mornings, it was all she could do to hold herself together until she could get him off to work and the children off to school. Then she could have that drink and, perhaps, the fifth or sixth one would stay down.

Empties now were a problem. She couldn't just put them out with her garbage, for even her next-door neighbor didn't know Sally's problem. Sally used to get in her car and drive until she came to a vacant lot with high weeds. Then, being sure no cars were coming, she would toss the sack into the lot and roar away.

Gradually her dry periods became fewer and fewer. One morning she swore to herself she would not drink, ever. It was not until 4:30 p.m. that day that she broke down. The second day she renewed her vow. She held out until noon. The third day she started hitting the bottle as soon as her husband and children left.

That was when she decided she needed help.

She same to the Education and Information Center of the Committee on Alcoholism for Greater New Orleans. The purpose of this group is to bring to people the message that alcoholism is a disease and that there are facilities to treat it.

Ashton Brisolara, the executive director, saw that Sally was an alcoholic—something she did not recognize herself yet. He took her to the Clinic for the Diagnosis and Treatment of Alcoholism, a state-operated and supported facility, down the hall from his office.

At the clinic are a counselor, a psychiatric social worker, a psychiatrist and a general practitioner, all full time, who pool their efforts to decide the best treatment for the patient. In Sally's case they agreed she should go to the Alcoholic Treatment Service in Mandeville. This is a separate ward containing 36 beds in attractive motel-type accommodations: 24 are for men, 12 for women.

Now Sally Understands

It was at Mandeville that Sally at last understood that she was an alcoholic. She was different from many suffering from the disease in that she did not have a period of social drinking that gradually became heavier until she lost control. In her case she had had no control since the time when she found the keg of muscadine wine under the cistern that hot summer afternoon so long ago.

"The knowledge that I am an alcoholic and will always be an alcoholic has helped me fight the disease," she says. "I want to tell my story—not only because it might help other alcoholics but because, in telling it, I'm strengthening my own determination to stay dry."

THE PERSONALITY OF THE ALCOHOLIC

BY HOWARD T. BLANE, Ph.D.

EVERYONE knows about alcoholics; yet we who work in the field, who attempt to obtain precise knowledge of the alcoholic in the interests of treatment and of prevention, feel less certain about what alcoholics are like. We do know that there are vast differences among individual alcoholics, and that these differences depend on a large array of factors, such as social and cultural backgrounds, intelligence and education, the stage to which drinking behavior has progressed, and so on. However, we also know that there are certain personality characteristics, traits, consistent patterns of behaviors which occur commonly among alcoholics.

These traits are not present in all alcoholics, but are common enough to warrant description. Nor are they of equal intensity; that is, the patterning, the organization of the traits varies from individual to individual. Further, some or all of these traits are seen in persons who are not alcoholic; indeed, if we examine ourselves we are apt to see these traits, the difference being that they are transitory, or that they don't rule us to the point that they prevent us from doing what we want to do or make us do what we don't want to do, as occurs in the case of the alcoholic.

Certain personality traits and modes of behavior, sometimes present in non-alcoholics, occur commonly among alcoholics though their intensity may vary.

We do not know precisely the whys of becoming alcoholic. Certainly, the etiology of the disease is not any simple and single cause-and-effect relationship, although such kinds of relationships have been put forth as explanations many times in the past. We currently believe that alcoholism is the product of a complex combination of factors, some of which we know more of than others.

Stated in the most general terms, this position says that a person with a certain psychological and probably physiological background, who lives in a particular society and culture, will under specified circumstances, in all likelihood become alcoholic. We know quite a bit about some of the terms of this formulation. For

This article was originally published in a report of the proceedings of a regional conference on "The Role of the Nurse in the Care of the Alcoholic Patient in a General Hospital" prepared by the Division of Alcoholism, Massachusetts Department of Public Health. Reprinted by permission of the author. *Dr. Howard T. Blane is an assistant psychologist, Massachusetts General Hospital and research associate, Harvard Medical School.*

example, we know that alcoholism among Jews and Chinese is almost nonexistent, but has a high incidence among the Irish and Scandinavians. Another example, but less convincing than the first, is that alcoholics frequently have alcoholic fathers. It is obvious, though, that not all alcoholic fathers have alcoholic children.

In any event, it is because we know relatively so little about why people become alcoholic and also because the several theories of etiology lack conviction that I have decided not to go any further into them.

Now let me describe to you the personality characteristics which are commonly seen in alcoholics.

Unrealistic Interpretations

Perhaps the most commonly observed trait among alcoholics is what we refer to as *low frustration tolerance*. What I mean by this is that when a wish, or request, or desire, or demand of the alcoholic is not gratified immediately, when its object is not achieved, the alcoholic tends to react with anger, with insistence that his wish be fulfilled, or with withdrawal from the frustrating situation. Most of us have the capacity to delay gratification as well as the ability to tolerate great degrees of frustration, but this kind of delay and tolerance is virtually foreign to the alcoholic.

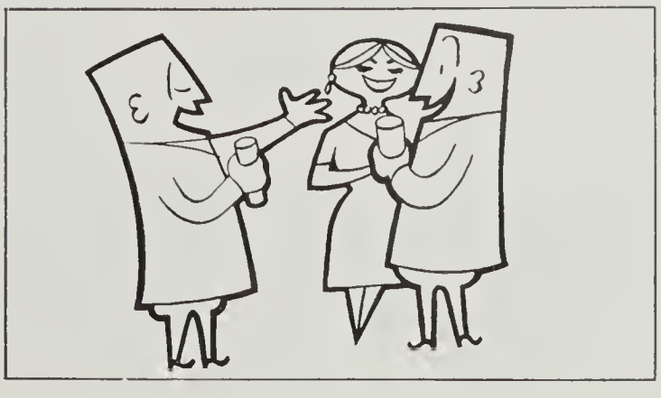
Let me make this rather abstract term more graphic by an illustration. An alcoholic has an appointment to see his physician for a medical ailment. When he arrives, the doctor is examining another patient and is behind in his schedule. The alcoholic expostulates with the doctor's secretary: he had an appointment at 2:30; he hasn't got all day; he has to be some place else shortly; and so on. Or, alternately, he waits for a few minutes, and then quietly leaves,

probably carrying his resentment with him.

In other words, the alcoholic is very apt to interpret ordinary frustrations not in terms of reality but as rejections directed personally toward him. This sort of reaction occurs in the most mundane situations: being waited on in a restaurant, delay of an ordered drink, and so on. How such behavior, so often repeated by the alcoholic, affects his relationships at home or on the job is not difficult to imagine.

Genuine, But Superficial

A second trait seen in many alcoholics is their *sociability*. They are frequently engaging individuals, enjoy the company of convivial groups, and can be charming companions. They have a lively sense of humor and are often good story tellers. This sociability frequently and paradoxically co-exists in alcoholics who are unable to maintain permanent, mutually satisfying relationships with wife, parents, or friends, or whose significant relationships are shot



through with guilt, hostility, threats of rejection, and mutual recriminations.

Upon closer examination, this sociability, genuine and likable as it is, rarely occurs within the context of any deeply positive emotional relationship, but is superficial in the sense that anyone who comes into contact with the alcoholic will be the recipient of feelings of good fellowship and camaraderie. Furthermore, usually present in the alcoholic's social charm is a need to impress others with his worth, his adventures, his accomplishments in life, with well-worked-out reasons which serve to explain whatever failures he has experienced.

"Call Me Bum"

A third characteristic of the alcoholic, which again presents an apparent paradox, is his *feeling of inferiority combined with attitudes of superiority.* Attitudes of superiority are readily observable in the alcoholic's general behavior. Although the expression of these feelings may take many forms, they are most often limited to the following kinds of behavior:

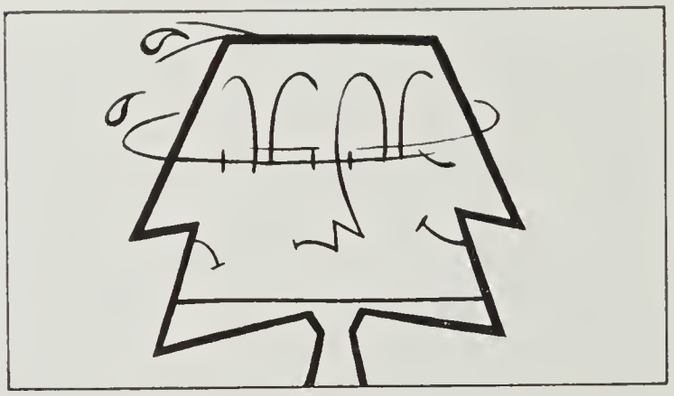
(1) The alcoholic acts as if he assumed that it is his right to get preferential treatment in life, that the satisfaction of his needs and desires comes before that of others. We have already seen indications of this when I have spoken of his low frustration tolerance.

(2) He speaks of his importance, either his own personal importance or that which he derives from his association with important and influential people; he may dwell on his past accomplishments, exploits and so on, or tell you of such-and-such an important figure with whom he is or has been close friends, and of what this person has done or is going to do for him.

The alcoholic's feelings of inferiority are seldom directly expressed by him or directly observed by others. This, of course, is quite understandable, since no one likes to admit to himself or to others that he feels less adequate than his fellowmen.

Our first line of evidence is by indirection: People who habitually have to impress others (and thus themselves) with their own worth frequently suffer from doubts as to their ability, adequacy, and so on.

With our second line of evidence we feel more secure; that is, a recurrent observation in prolonged psychotherapy with alcoholics is that they eventually bring up violent feel-



ings of hatred toward themselves, and speak convincingly of their lack of worth, of their inadequacy.

These are not the isolated or specific feelings of the sort that we have when we are annoyed at ourselves for being unable to do some specific task. On the contrary, when the alcoholic is unable to accomplish even the most commonplace goal, this for him is just a confirmation of what he has known all along: that he feels just plain no good through and through. And further, this feeling can occur despite the most blatant evidence to the contrary. The alcoholic may have all sorts of substantial achievements to his credit and be a person of considerable success but, nevertheless, pervasive feelings

of worthlessness, of low self-esteem, accompany his every thought or action.

Another occasion when the alcoholic expresses feelings of being no good is either in the midst of an alcoholic spree or when he has just stopped drinking, is physically ill, and is filled with guilt and remorse over his drinking behavior.

Recently one of our psychiatrists was seeing an alcoholic patient in the emergency ward. The patient insisted that the doctor call him Bum, and was obviously perturbed when the doctor naturally refused and continued to address him as Mister. When questioned, the patient elaborated convincingly, and with feeling, on why he ought to be called Bum and did not deserve to be called Mister.

The alcoholic most of the time, of course, tries to avoid feelings of low self-esteem, and part of his avoidance technique is to impress not only others but himself with his own worth. In other words, we see his feelings and fantasies of superiority in part at least as a defense against perceiving his feelings of worthlessness. We also suspect, however, that some of his feelings of superiority stem from a more basic source in his personality structure.

Many Fears and Anxieties

Most alcoholics are *fearful* individuals. This may seem to contradict what I said about their sociability and their often garrulous need to impress others. The contradiction, however, is only apparent, since the alcoholic's sociability is confined to certain situations and does not appear in others, and the fearfulness behind his attempts to impress others is frequently all too readily evident.

What is the alcoholic afraid of?

Experience in therapy with alcoholics shows that their fears and anxieties can be numerous, and highly individual with respect to the person's unique life experiences and background. For our purposes, the primary thing to take note of is that the alcoholic is afraid of anything that poses a challenge to him and to his abilities.

This over-all formulation covers a wide range of behaviors. Thus, the alcoholic is fearful of trying to obtain a job that is within his abilities and for which his past experience well equips him, especially if he feels the job to be a worthy one. This is one reason why alcoholics are often found working in menial jobs, for instance, as dishwashers, kitchen helpers, or janitors, even though they may be reasonably well educated and have training in jobs which are higher in the occupational scale.

The alcoholic is also fearful of entering into relationships in which he feels demands may be made upon him involving responsibility and mutuality, and by mutuality I mean respect for the other person, as well as trust in his respect for you. In the kinds of sociability I described before such mutuality and responsibility are minor aspects and may often be nonexistent.

The alcoholic's fearfulness in human relationships is in large part the reason for the immense difficulty experienced in engaging him in a treatment relationship.

This anxiety places the professional person in a most awkward position with regard to reaching the alcoholic. To be treated with respect is frightening to him, and he will most often react with either defensive anger or attempts to run from the relationship as speedily as he can. To be treated with disrespect, with derision, open hostility, or a moralizing attitude is what the alcoholic expects, for it confirms him in his view that the world is hostile, non-understanding, and not to be trusted.

It is this self-created conception of the world that the alcoholic uses as a major reason for his continued drinking behavior. If he is able to accept the respect of others, this is already an excellent sign of potential recovery, and is a first step to discontinuing drinking. The alcoholic seems aware of this, and while some part of himself would like not to be alcoholic, another and nearly always stronger part is tremendously fearful of not being an alcoholic. For these reasons the alcoholic shies violently away from any potentially mutually respectful relationship.

Another aspect of the alcoholic's fearfulness has to do with testing himself and his capabilities. He won't shut up and he is afraid to put up. He is well able to tell others of his capacities, but this is bravado in the service of warding off feelings of inadequacy and helplessness. When it comes to the point of doing things which he feels will in a reality and action setting test his statements, the alcoholic becomes quite fearful, and under these conditions will more likely than not resort to flight. Should he get into a situation which he feels is a test, he is most apt to take the view that he has failed and will respond with depression or increased drinking behavior.

The alcoholic often impresses one as an expert at garnering failure, and as one who is equally expert in rationalizing failure as due to unavoidable external circumstances, such as his being victimized by a hostile environment. When he suffers a set back in reality or merely in his own mind's eye, he is frustrated and responds accordingly.

I want to emphasize again that the failures or defeats that the alcoholic feels he has suffered consist from our point of view of the minor irritations, the petty annoyances that beset us daily. However, they do assume major proportions in the alcoholic's mind, and he reacts as we might to a major blow in life. One can only guess what a burden life must be to the alcoholic, and what a Kafka-like nightmare he exists in. The writings of someone like Edgar Allan Poe, himself an alcoholic and drug addict, become understandable in these terms.

From Extremes to Flexibility

The fifth personality variable commonly seen among alcoholics involves *dependency* and its various expressions. While many alcoholics would not, on the basis of their surface behavior, be described as dependent, clinical and therapeutic experience teaches us that dependent needs are nearly always of central importance in the alcoholic's personality makeup.

One group of patients, who quite openly seek to be taken care of and to be given to, we infer to have strong dependent needs for which they seek direct gratification. Alcoholics in this group expect and actively try to get others and the environment to meet their needs. They show a marked lack of initiative, will do little on their own, and appear to function most adequately under the firm and close guidance of those around them. They are often drifters who develop relationships with a

dominant man or woman who will protect and take care of them.

A second extreme group of patients includes alcoholics who are quite the opposite to the above. Relationships that involve any open expression of dependent behavior are avoided. They see themselves as quite capable of taking care of themselves, usually deny any problems involving drinking, and pride themselves on their masculine, physical prowess. The statement "He can drink like a man" is among their highest forms of praise. That they do s e e k gratification of dependent needs, however, is apparent, though such expressions are indirect. The bonhomie of the tavern, the sometimes maudlin avowals of friendship, and indeed the dependency on alcohol itself are examples of this.

We infer that this type of alcoholic has intense dependent needs, the direct satisfaction of which is extremely unacceptable and frightening to him. The basic fear seems to be that directly dependent behavior makes him look like a little boy, like a "sissy"; in other words, he fears that expressed dependency will drastically alter his tenuous image of himself, will destroy his identity as a man.

A third group of alcoholics lies midway between the extremes I have just described. These patients fluctuate, according to circumstances and their current life situation, between denial of dependent needs and displays of direct gratification.

In terms of reaching them therapeutically, we find for several reasons that they are more promising than either of the groups above.

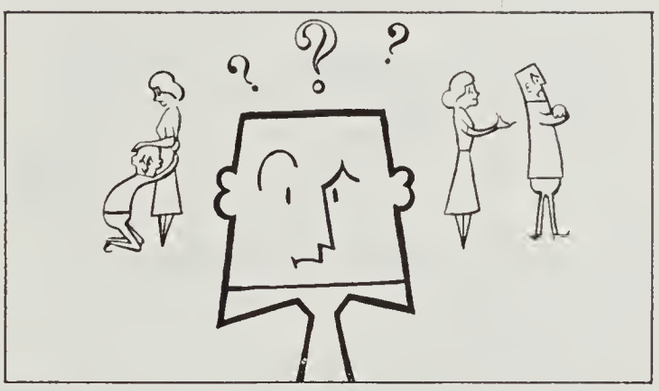
First, they are not so frightened of their dependent wishes that they have to deny them completely.

Second, they are not apt to regress to a severe state of dependent behavior, either because their needs are not so intense or because of the fear they do have of complete expression of dependent behavior.

Third, they are still in an active and painful state of conflict, the hoped-for alleviation of which may prompt them to seek help. Both of the other groups have in a very real sense resolved the conflict, one by denying its existence, the other by regressing to marked dependent behavior.

Fourth, the very fact that these individuals vary their behavior with respect to dependent needs implies a certain flexibility which is a positive sign.

Despite the notion that these alcoholics are potentially more therapeutically rewarding, their behavior



can be confusing and annoying because it is so contradictory. On one occasion, an alcoholic of this type may actively seek help and wish to be taken care of, and on the next deny that he ever requested anything, state that he is quite capable of taking care of any problems he might have, and so on.

I have listed and briefly described five personality traits or variables that are commonly seen among alcoholics. These include (1) low frustration tolerance, (2) sociability combined with more or less difficulty in maintaining long-term human relationships, (3) feelings of inadequacy, with defensive compensation by attitudes of prowess and worth, (4) fearfulness, and (5) dependency.

Currently in North Carolina there are thirteen

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—
Citizens' Committee on Alcoholism
Sgt. Carrol R. Owens, Chairman
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary — Phone: 942-7253

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellermann, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
211 Snow Building
Mrs. Olga Davis, Executive Director — Phone: 682-5227

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
Rev. Edward Laffman, Director

LAURINBURG
Scotland County Citizens Committee on Alcoholism
308 State Bank Building—P. O. Box 1229
M. L. Walters, Executive Secretary — Phone 276-2209

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
225 West Morehead Street, P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehablilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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Associate Director

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Medical Director

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Educational Director

INVENTORY

VOLUME 11 NUMBER 5

JANUARY-FEBRUARY, 1962

RALEIGH, N. C.

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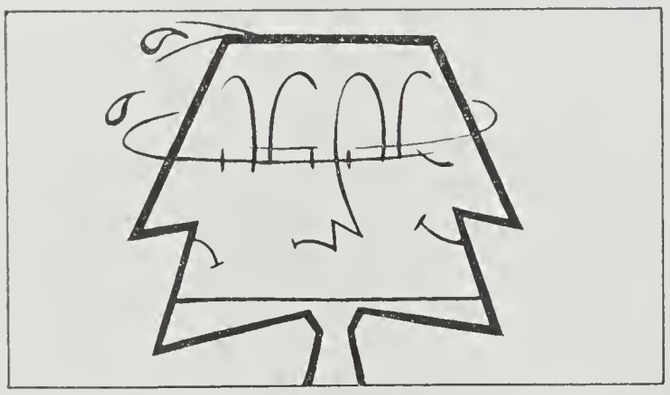
ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

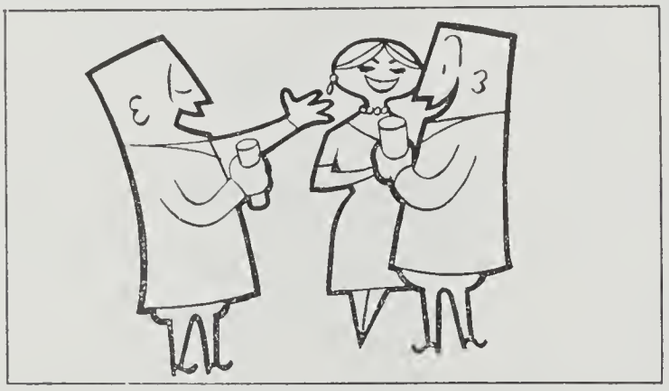
THE PERSONALITY OF THE ALCOHOLIC

BY HOWARD T. BLANE, Ph.D.

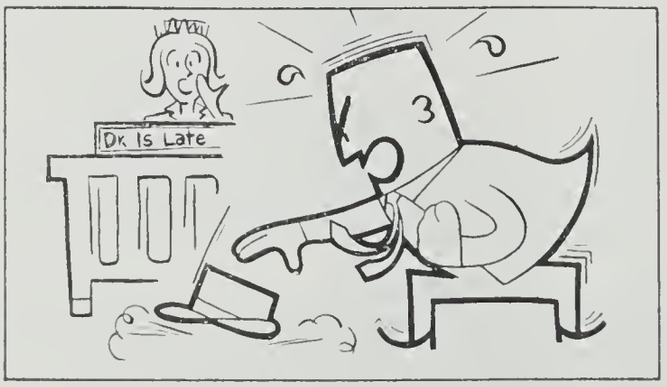


Inferiority—Superiority

Fearfulness



Sociability



Low Frustration Tolerance

THERE are five personality traits or variables commonly seen among alcoholics. These include low frustration tolerance, sociability combined with more or less difficulty in maintaining long-term human relationships, feelings of inadequacy with defensive compensation by attitudes of prowess and worth, fearfulness, and dependency.

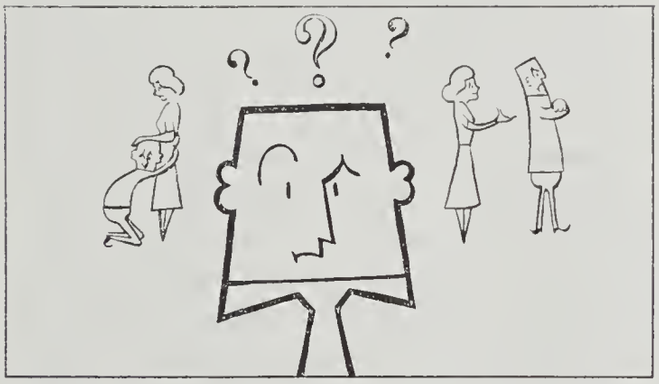
Let us now consider some of the implications of these traits in terms of the alcoholic's relationships to the world, especially with reference to his contacts with caretaking personnel (workers in a community, such as nurses, doctors, teachers, ministers and law enforcement officers; who come in contact with individuals at a time when they are in a predicament of one sort or another and need some help).

Certain aspects of the alcoholic's behavior that are analogous to behaviors considered "normal" in small children are highly unacceptable in adults.

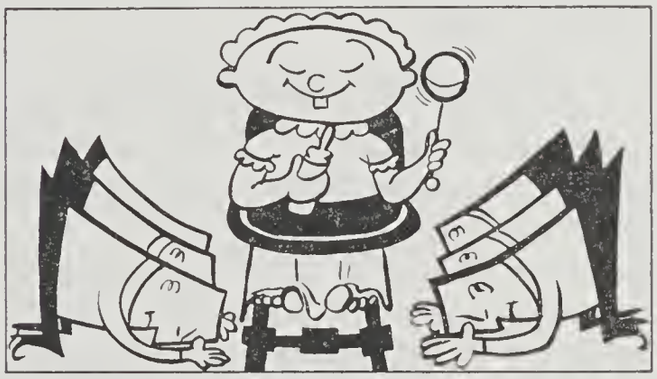
This article is a continuation of Dr. Howard T. Blane's "The Personality of the Alcoholic", which appeared in November-December issue of Inventory.

derstandable when we assume that certain aspects of the alcoholic's personality are analogous to those seen among children.

Small children are egocentric; that is, from their viewpoint the world revolves around them and has no other reason for existing than for the satisfaction of their wishes. This childhood egocentrism carries with it implications of omnipotence, and fantasies of children containing themes of being all powerful bear this out. We must assume that much of the superiority behavior of alcoholics has an analogous origin. Alcoholics, like children, are highly egocentric and have fantasies of omnipotence.



Dependency



Childlike Egocentricity

With the possible exception of the alcoholic's difficulty in maintaining mutually satisfying relationships, the above traits are commonly seen as a natural part of the development process in children, and for this reason alcoholics are often described as "infantile", "immature", or "regressed" personalities. Much of their behavior is reminiscent of that seen in small children. It is as if they had either never learned to grow up psychologically or, alternately, that some stumbling block occurred in their adulthood which resulted in a return to earlier, more childlike modes of behavior and of coping with problems.

The alcoholic's attitudes of superiority are, in part, a defensive reflection of feelings of inadequacy. In other words, his superiority has a more basic source. This is more un-

The case is similar for low-frustration tolerance. It is a common observation that children, if their wishes are not satisfied on the spot, react with rage, temper tantrums, or sullen withdrawal. Part of growing up is the learning of methods to delay gratification, to put off immediate satisfaction for the sake of later and perhaps more rewarding outcomes; that is, to build up tolerance for frustration. The alcoholic, as we have seen, is unable to tolerate frustration and, like the child, reacts with rage or withdrawal.

With respect to dependency, the child, because of his relative physical helplessness and also because he is egocentric and demands satisfaction

of all his needs, is highly dependent. If his needs to be taken care of are not met, he is frustrated and will more often than not respond with indications of anger and pain. However, as the child grows older he becomes more and more interested in doing things for himself, refuses the assistance of others, and shows evidence of marked strivings for independence, self-sufficiency, and autonomy. Certain stages in his development are characterized by kaleidoscopic shifts between dependence and independence. Against this background of the childhood vicissitudes of dependent needs, one may view the alcoholic and his coping with similar needs.

Unacceptable Adult Behaviors

The central point I wish to make about the analogies between the child and the alcoholic is this: such behaviors in a child are considered "normal" and by and large acceptable, but analogous behaviors in an adult are highly unacceptable and are a source of anxiety in others. This is one of the reasons why alcoholics are reacted to by many with attitudes of contempt, amusement or moral indignation.

The often contradictory behavior of the alcoholic, his tendency to express hostility when his needs are frustrated, and his apparent lack of human dignity when drinking heavily serve to provoke hostility in those around him. He acts much of the time as though he wished for hostility and rejection from others; as though he wished to destroy relationships with others.

The entire life pattern of the alcoholic points toward a gradual self-destruction: the marital instability of alcoholics is well known; the deterioration of occupational achievement is apparent in many; physical disintegration of serious proportions may occur; and decline of intellectual and other mental faculties is frequently severe. This pattern has been called "slow suicide" by some, and yet the alcoholic persists in this self-destructive process. Because of the evident self-destructive aspects of the alcoholic's life, and because of the positive association between alcoholism and suicide, some investigators have postulated a self-destructive urge as a basic factor in the alcoholic's motivational makeup.

The view may also be taken that the alcoholic's self-destructive behavior is an outcome secondary to his commitment to alcohol and its effects. This conception holds that the alcoholic has discovered a solution to his conflict through excessive alcohol intake. Though this solution is painful to him, involves loss of self-respect, estrangement from others, and gradual destruction, he feels it is less painful than dealing directly with his conflicts. Part of the pathos of the alcoholic is that while slowly killing himself, physically and emotionally, he feels that he is saving himself from a threat which doesn't exist in outer reality but only in his fantasies.

The traits of alcoholics mentioned are not meant to be all-inclusive, but are intended as general and, for the most part, easily observable guideposts. Other lists of traits could have been made: for instance, I could have spoken of orality, depression, and ambivalence and so on. However, I wanted not only to keep with common characteristics, but as close to observables as I could.

Another point concerns the variable expression of the behaviors discussed. Important in this connection is that the traits mentioned may be more or less apparent according to the stage of alcoholism to which the individual has progressed, and also on whether the alcoholic is drinking

heavily at the time he is seen.

When not drinking, for example, a spree drinker may be a dependent, mildly fearful individual who appears quiet and unassuming. On a spree, however, garrulous expressions of self-importance, anger at supposed slights, and defensive expressions of independence become primary behaviors.

You will notice that I have not described the personality of alcoholics within the more standard classifications of the mentally ill, such as neuroses, or the schizophrenias, or the mood disorders. The reason for this is that a number of studies have shown that when alcoholics are given formal psychiatric diagnoses, these diagnoses tend to fall throughout the range of possible diagnoses. Students of alcoholism have many times attempted to devise meaningful diagnostic categories; their success, however, has been minimal.

For example, one system divides chronic drinkers into four classes—the social, the reactive, the neurotic, and the addictive, in order of severity of social disintegration and psychological disturbance. In practice, however, the majority of chronic drinkers who are seen in hospitals, clinics, or other caretaking agencies fall into the addictive groups, with very few neurotic drinkers and almost no social or reactive drinkers. Even among the addictive group of alcoholics, wide individual variations in personality makeup are known to occur.

You have seen how adept alcoholics are at provoking hostility or derision in others, and angry or derisive attitudes on the part of others confirm the alcoholic in his conception of the world, thus reaffirming the life pattern which the alcoholic uses as a justification for excessive drinking behavior. Obviously, such attitudes are antitherapeutic. When, on the other hand, the alcoholic is treated matter of factly with the same respect as that shown other patients, he may feel uncomfortable, he may fight against it, he may withdraw from it, but such treatment, nevertheless, has a positive and potentially beneficial meaning to him.

In a study at the Mt. Zion Hospital in San Francisco, alcoholics were not segregated; that is, they were hospitalized on regular medical wards and treated as other ill persons. One patient said: "You are treated like you are worth keeping instead of being just another drunk." Another patient said that in the past "I was shook up long after I dried out because of locks and keys and being regarded more as an inmate than a patient, while here I felt no stigma of the boozer attached to my care."

Change In Attitudes

Another interesting aspect of this study involves the contrast between the opinions of the nursing staff before and after the nonsegregation program. Before the study, a majority of the nurses felt that such a program would involve extensive management problems and more work, and would have a deleterious effect upon other medical patients on the wards. Some felt that special nurses would be required. Following the program, the nurses retaining these opinions were in the minority. This change in attitudes over a period of time is an indication that experience with doing for and reaching out to the alcoholic need not be a frustrating and unrewarding endeavor.

In dealing with alcoholics in hospitals and clinics, awareness of their diminished capacity to withstand frustration as well as their fearfulness can be an important aid.

Waiting and delays are inevitable in these settings and often result in withdrawal or anger. To explain to

the alcoholic when he will have to wait and reasons for it is an easy antidote. This can serve to reduce tension and decrease the alcoholic's notion that a delay is something directed toward him personally. The patient's fearfulness can often be reduced by describing what procedures are to be done and the reasons for them. In my own work involving psychological test evaluations of alcoholics I find that they are initially quite fearful and that giving them straightforward explanations as to the reasons for the consultation reduces their anxiety.

The alcoholic, because of his low frustration tolerance, has a great deal of difficulty in keeping to the rules and regulations necessary in caretaking settings, since rules by their very nature involve frustration, however minimal.

Needs Controls

Violation of rules can be one of the most disturbing things to caretakers, and can also disrupt the organization of a ward or clinic. To change regulations just for alcoholics or to be overly permissive with regard to rules is just as much an error as to react punitively with regard to infractions. Either of these means to the alcoholic that he is misunderstood, and he has as little trust in permissive as he does in punitive persons. He needs and seeks the controls and limits against which he struggles, and in this he again reminds one of the small child. He will repeatedly attempt to break rules to test the limits of the situation he is in. But limits have to be set, and have to be adhered to, and if it is made clear to the alcoholic that the consequences of going beyond limits are not punitive but ultimately in his best interests, he less often finds it necessary to exceed limits.

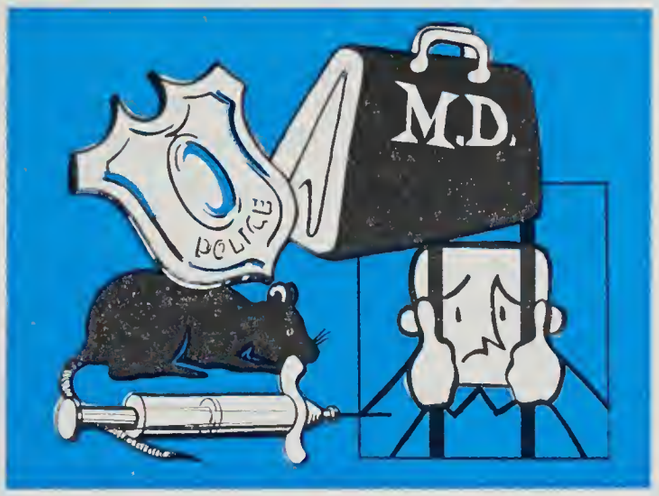
For instance, in psychotherapy with alcoholics the patient will not be seen if he is intoxicated when he comes to an interview; nor are persistent phone calls permitted. These rules serve to reduce the patient's dependency and his attempts to involve the therapist in his feelings of low self-esteem.

The insistent demands of the alcoholic and his intense attempts to provoke rejection and hostility require that treatment be carried out in a team setting.

We have recently established a program, the goal of which is to get alcoholics coming to our emergency ward into a treatment relationship. To deal with these men who are most often homeless, indigent and physically ill, we have established teams of psychiatrists and social workers to work with them. These teams utilize the ancillary services of the hospital in a coordinated effort to help the patient: these services involve physicians, nurses and ward personnel, as well as administrative and other nonmedical personnel with whom the patient must interact.

We have found that this approach has been exceptionally successful in getting alcoholics into treatment relationships. Among our guiding principles have been our knowledge and understanding of the alcoholic's fear of establishing meaningful relationships with others, his low frustration tolerance, his needs for controls, and his dependency.

Alcoholics are sick persons, and when we see them in a hospital setting they are usually physically as well as psychologically ill. The tendency to focus on the physical aspect of the disease is understandable, but much can be gained when we treat the whole man, with an appreciation and understanding of the personality factors that play such a crucial role in his illness.



POLICE, MEDICINE and ALCOHOLISM

BY ZACHARY TRAWICK, M.D.

DIRECTOR AND STAFF PHYSICIAN
MONTGOMERY CLINIC
ALABAMA COMMISSION ON ALCOHOLISM

This article, reprinted by permission of The Challenge, was originally given as a talk at a Police Training Institute in Montgomery, Alabama.

A physician describes symptoms and complications of alcoholic intoxication.

FROM a practical point of view for the law enforcement officer, the acute symptoms of alcoholic intoxication may be divided into two groups because they must be handled differently. Alcohol depresses first the front part of the brain that has to do with reasoning and with holding a person in check, so that it seems that he is in an excited stage. Later, it depresses the whole brain.

The first group may be called the inebriation or excitement stage. Only a moderate amount of alcohol is necessary to produce the symptoms. The person gets a sense of warmth, and a little tingling in his skin. His face becomes somewhat flushed. He becomes talkative because of the removal of inhibitions. He develops a litte mild dizziness that doesn't really show unless he is watched very closely. He develops a false sense of well being; he is relaxed and happy and overconfident. This is the kind of man that races his automobile down the road at 100 miles per hour and has a wreck. He thinks he is doing fine; he thinks he can drive better than everybody else. As more alcohol is consumed he develops loud speech and boisterous behavior. He becomes noticeably clumsy. His reflexes and his ability to respond to quick emergencies decrease.

Finally, he begins staggering and may eventually develop anti-social behavior and commit a crime. These are all symptoms of the inebriation or excitement phase. These people may also have a real psychotic episode becoming truly detached from reality and not knowing where they are or what they are doing. They frequently have periods of amnesia, called blackouts, during which they are entirely conscious and may look normal, but, the next day, not remember what happened.

The second group of symptoms may be called alcoholic anesthesia. Alcohol is not used for a medical anesthetic, but it will produce anesthesia and coma and death, just as enough ether will. As more alcohol is added to the blood stream, the brain becomes progressively more anesthetized and shows it. Unfortunately, there is only a narrow margin between the excited and depressed phases. In other words, with slight increase in alcohol blood level, a

person goes into coma and may die.

The signs of coma are very important because of the possibility of death. The patient shows more depressive signs—generally slowing bodily functions, becoming increasingly drowsy, more argumentative, but now, a sort of dull and senseless argument, when before, he could argue brightly and rationally. Now he becomes weepy, cries, gets angry over nothing, and wants to fight at the least provocation. Usually by this time he may have started developing some nausea and vomiting because of the toxic effect of alcohol on what we believe is the vomiting center in the brain. He eventually may develop some definite physical signs such as paleness, pallor of the skin. If you are looking at him, you will see his eyes crossed or pointing out. He has a ringing in his ears, feels numb all over, and may see double. His pulse becomes rapid; the pupils of his eyes, where they were tiny in the first stage, at this stage become very large. Later, he goes into increasing stupor from which it is difficult to arouse him and he may die from one or two things. He may go into vascular collapse (shock). Signs and symptoms of this are paleness, sweating, clammy skin, fainting and falling blood pressure. Or he may die in coma, without shock, just from the extreme toxic effects of alcohol on the brain. This may happen in two or three hours from the time you first see the person if he has had a sufficiently large amount of alcohol before you happen to get to him.

If he does not die, and if he does not drink any more alcohol, he will recover and develop the familiar hangover. In this, there is lassitude or laziness. Other signs are dehydration, loose, dry skin, sunken eyeballs, headache and vomiting. The skin is still pale, clammy and sweaty, but this time the paleness and sweating are not serious because it is obvious this patient is conscious and recovering whereas before he was getting more and more drowsy and more and more depressed. The pulse is still rapid.

In the hangover stage, there are two important things which are very frightening. One is serious and the other is not. He may have convulsions. This may happen to someone who has never had a convulsion before; it is quite frequent with people who are prone to have epilepsy anyway. The reason for this is that alcohol is a depressant and, while the patient is under the influence, it acts just as any other medicine to prevent convulsions, but when it is withdrawn there is a rebound phenomenon: the brain functions at an even higher level than normally and at this high level convulsions are not infrequent. They are frightening but they are not serious. The two dangers of convulsions are that the patient may fall and hurt himself or his airway may be blocked; or he could conceivably die from lack of oxygen, but that is quite rare.

D.T.'s, Serious Complication

The really serious possibility in the hangover stage is delirium tremens or D.T.'s. About 50% of people who have true D. T.'s and do not get treated, die.

What should an officer do about these two stages of acute intoxication? In the excited stage you must protect the patient from himself and you must keep him from hurting others. That is really all that is necessary because he has not had enough alcohol to give him any serious medical illness.

In the depressed phase, you must be quite careful because this is the borderline zone where he can die or develop serious complications. It is a good idea to call a doctor. If in

doubt, do so. The reason for this, of course, is the possibility of death from the effect on the brain of an overwhelming dose of alcohol. The client may fool the officer by drinking a pint or more just before he is apprehended, and appear not to be very intoxicated when first seen. However, he gets more and more intoxicated in the following hour or two and, if he is is in a cell somewhere and not watched, he could easily die from absorption of the alcohol from his stomach during that time. Be careful because he may go into coma, D.T.'s or some other related complication.

What we are concerned with in the alcoholism clinic is chronic alcoholism. The chronic alcoholic has the same signs and symptoms as anyone else who has had too much to drink, when seen by the officer. The only difference is that he will get drunk more often. He will go on long binges while a man who is not a chronic alcholic probably will not. A chronic alcoholic gets drunk in the mornings and it is impossible for him to control the amount he drinks after he has had the first drink. It is very difficult for him to stop, but otherwise the signs and symptoms are the same. The officer cannot tell from just seeing a man the first time, or the second, or the third, whether he is really a chronic alcoholic or not, but it does not matter because the officer is interested in the immediate effects and what he must do about them. Contrary to popular opinion, less than about 5% of chronic alcoholics are of the skid row type, so it is not necessary to be this type to be a chronic alcoholic. With chronic alcoholism, and after long binges, the withdrawal symptoms are likely to be more severe than with one-night drinking sprees.

Alcoholics are more likely to get infectious diseases of all kinds. Their body resistance is lowered to any kind of infection, particularly to tuberculosis, pneumonia, and meningitis and, because of their lowered inhibitions, probably venereal diseases. These are all things that may develop while a man is in jail and with which the officer should be familiar enough to call a doctor if it seems necessary.

One of the less serious complications that many alcoholics frequently have is a condition called chronic gastritis. Alcohol is a poison to the lining of the stomach and it actually eats out the superficial lining of the stomach if enough is drunk in sufficiently concentrated form. For four or five days after this happens, the patient may have nausea and vomiting and pain up in the top part of the stomach and an inability to eat any solid food. He will be quite miserable, but he usually gets over this without any trouble.

Another more serious complication, but one that is usually easily recognized, is cirrhosis of the liver. This probably does not occur as frequently as most people think. There is still a lot of argument about whether alcohol alone can cause cirrhosis, but most doctors think it cannot. They think that some other agent or condition is necessary along with alcoholism; something such as a preexisting infection in the liver, called hepatitis, or a long standing protein depletion, inadequate diet or both, and probably some other factors, too. With cirrhosis of the liver in its advanced stage, the person will have yellow skin, swelling of the abdomen and thin arms and legs. They have flabby muscles, and a big liver that you can see and feel very easily in the upper right part of the abdomen. This is serious but not immediately serious like some of the other things.

A man who comes in drunk may

also have some kind of heart condition. As a matter of fact, he is more likely to have a heart condition in a drunken state than sober because alcohol in the excitatory stage produces flushing of the skin and a rapid pulse, some rise in blood pressure, over activity and boisterousness, and all of this puts a strain on the heart. A heart that is already on the borderline and ready to go into failure, may fail under the strain. A man can be drunk and have a heart attack at the same time. It is very difficult to tell the difference and the officer can really be in a quandry. When a man says he has a terrible pain in his chest, the officer is taking a bad risk not to do something.

Another minor, but frequent, complication is something called peripheral neuritis. The patient gets pains and tingling and a sensation of pins and needles sticking in his arms, legs, feet and toes. He may get a wrist drop—cannot lift his wrist, or foot drop—dragging the feet as he walks. These are due to the effects of alcohol on the nerves that go to the feet and hands. It actually poisons the nerves and stops them from functioning. It is a frightening thing to the patient but he can usually get over it with weeks or months of good diet and proper vitamins.

Convulsive disorders are not infrequently associated with alcohol. They usually occur more during the first few hours to the first few days after alcohol is withdrawn. It is quite frightening for someone to watch, but it is not really serious if the person is kept from hurting himself while it is happening. Convulsions only last a few minutes, and then the alcoholic goes into a deep sleep and is all right. When one starts biting his tongue uncontrollably, you are tempted to stick your fingers in his mouth to keep him from chewing his tongue. He can bite a finger off. Such a person has no concept of what is going on. He is not trying to bite the finger off and he doesn't know what he is doing. It is much better to put something soft such as a rolled up shirt tail in the corner of his mouth. This will keep him from closing his teeth all the way to bite his tongue, and it will give him an air way. If there is medical equipment around, several tongue blades put together are ideal for this, but anything soft that he won't hurt himself by biting is all right. It is all over in a few minutes and then the officer doesn't have to worry anymore, except that a man who has one convulsion may have more. If it seems that he may have another one, call the doctor.

Distinction Necessary

It is important to distinguish alcoholic hallucinosis from D. T.'s because the first condition is not really serious. In hallucinosis, the patient claims that he sees and hears things that are not really there. He is firmly convinced that they are there, and they are vivid and frightening and terrifying to him. Sometimes he may even have delusions and feel that someone is after his life or is trying to cut off his sex organs, or something like that. Other than these feelings, he is still aware of his surroundings and not really out of contact. He is rational, can talk, knows who you are, and what time of day it is. It is a strange thing to see a rational man tell you to look at a rat (that isn't there) sitting on the dresser, but this happens. In this condition the pulse is not elevated. He doesn't usually have fever. He is not sweating. He is not pale, not flushed. He looks all right, but he sees things.

This is in contrast with D. T.'s. Alcoholic hallucinosis lasts from a few minutes to a few hours or a half a

day, but D. T.'s are entirely different. With alcoholic hallucinosis there is no danger of anything bad happening to the patient except that it may go into D. T.'s. How do we tell that they have D. T.'s? They are really out of contact with their surroundings and don't know what is going on. You may have on a uniform and the patient will not recognize what it is or what it means. He doesn't know where he is or what time of day it is, what month it is or who the president of the U. S. is. He doesn't know anything. He usually has fever, feels hot; his face is flushed; his pulse is rapid; the heart is visibly pounding in his chest; and he usually has an intense tremor. (There usually is not a tremor in hallucinosis.) D.T.'s last from two to seven days. Anything that lasts less than two days and is not treated, is probably not D.T.'s. D.T.'s are rare and it is fortunate because of their serious nature. If you ever get one with D. T.'s, you had better get a doctor there in a hurry.

There are some later complications which are also rare and do not occur until a chronic alcoholic has been drinking for many years. One is called Wernicke syndrome where the part of the brain that controls balance has been permanently destroyed and the patient staggers and is unable to control his balance, particularly at night. He is unable to do skillful tasks with his fingers and has no coordination even though he is not drinking.

Another is called Korsakoff's psychosis. The mental hospitals are full of these people. They, for some reason, develop a real psychosis. It is permanent and they have delusions of grandeur and hallucinations even though they are not drinking.

Finally, they may have personality and intellectual deterioration from long term excessive use of alcohol and malnutrition. We need only be aware of these conditions.

There are other conditions entirely unrelated to alcohol intoxication, but which may be confused with it and get the law enforcement officer into difficulty. With these, a person may have half a drink or none at all and blood or chemical tests will show he is sober. Among these are drug intoxication, barium poisoning, accidentally gotten from rat or insect poison, mental conditions, brain tumors, brain absesses and brain infections, meningitis, encephalitis and polio. I remember a patient in New Orleans who had Wilson's Disease, a degeneration of the liver and part of the brain, probably hereditary, and having to do with body metabolism of copper, causing him to act silly and stagger. That poor man must have been arrested fifty times for being drunk, but he did not even drink alcohol.

There is also multiple sclerosis and other degenerative diseases, such as hardening of the arteries in the brain in elderly persons, causing them to be forgetful and wander aimlessly. Another condition is hypoglemia or low blood sugar that occurs in diabetics who take too much insulin and fail to eat enough to keep their blood sugar level up. Sometimes this happens to people who are not taking insulin, but usually you will find a card in their wallets saying "I am a diabetic". These are conditions where a person is conscious but staggering and appearing drunk.

There are also conditions that cause unconsciousness that may be mistaken for drunkenness. There may be a head injury, with no external markings, which occurred several days before with subsequent slow bleeding inside the brain, called a subdual hemotoma. Or there may be a diabetic coma from the person not

(Continued on Page 23)

Thanks for Inventory

Albert Schweitzer once said, "we ought to be springs of which people can satisfy their thirst for gratitude." I know that your desire to serve comes far ahead of your "thirst for gratitude", but I want to express my thanks for the publication, *Inventory*. It is for me both educational and informational, and many times it is also inspirational.

I thank you very much for the privilege of being on the mailing list.

Reverend Albert G. Edwards
Pastor, First Presbyterian Church
Raleigh, N. C.

Information Needed

Please send me information on how to help an alcoholic. It will be greatly appreciated as we know of someone we would be glad to help if we only knew how.

Anonymous
Kinston, N. C.

Help For AA Group

I am an active member in the Gastonia AA group and would appreciate being placed on the mailing list of *Inventory*. We need all the assistance possible. The need here is great and the group is yet small. This work is just beginning here.

Anonymous
Gastonia, N. C.

Requested For Library

Kindly place our School of Nursing on your mailing list so that *Inventory* may become a part of our professional library.

Our Chaplain introduced us to your magazine, and to him we will be ever grateful.

Mrs. Ruth B. Warren, Principal
School of Nursing
Rochester State Hospital
Rochester, New York

Student Writes

I am planning a course, "Pros and Cons of Drinking", to be taught on the 9th grade level. I would appreciate it if you could send any information you have on how to set up such a course.

Ken Thompson
Duke University
Durham, N. C.

Nursing Education

We would appreciate your placing us on your mailing list for *Inventory*. This publication will be used in our Nursing Education programs for Nursing Assistants and members of our professional staff.

Mrs. Jurhetta N. Smoot, RN
Asst. Chief, Nursing Education
Veteran's Administration Hospital
Northport, L. I., New York

Tuberculous Alcoholics

Recently I have read several issues of *Inventory* and have found them to be both stimulating and informative. As you undoubtedly know, a large percentage of tuberculosis patients have an alcoholic problem and that simultaneous treatment of both diseases must be carried out if the patient is to be rehabilitated and restored to the community.

Ralph G. Lewis
Medical Social Worker
Sanatorium Division
Department of Hospitals
Boston, Massachusetts

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: If you have recently moved, or plan to do so, please notify us of your change of address so that you may continue to receive Inventory promptly.

BIRMINGHAM, ALABAMA: A regional conference on "Developing a State-Wide Alcohol Education Program" will be held January 30-February 1 at the Thomas Jefferson Hotel in Birmingham. Dr. Norbert L. Kelly will serve as a consultant at the conference and will speak on "Recognizing Strengths and Barriers Within the Community Structure." Also representing the NCARP at the Alabama meeting will be educational director George H. Adams.

RALEIGH, N. C.: The NCARP is pleased to note the formation of two more local alcoholism programs in North Carolina. The Craven County Council on Alcoholism, Inc., with offices at 409½ Broad Street in New Bern, N. C., was established several weeks ago. The council is composed of twenty members representing different sections of Craven County, five of whom act as executive directors and one as executive secretary—Mr. Gray Wheeler. The other local program, which is in the process of drawing up a budget and getting organized, is in Wilmington. Mrs. Margaret Davis is its executive secretary.

GREENVILLE, N. C.: The North Carolina Joint Council on Health and Citizenship in Greenville recently invited George Adams to conduct a session on "Some Facts About Alcohol" at the organization's health education seminar for teachers. Dr. Andrew A. Best, a local physician, is the director and an instructor for the seminar which meets every Wednesday evening. Teachers throughout Eastern North Carolina come voluntarily to attend each weekly session.

DURHAM, N. C.: A conference on the Homeless Man Alcoholic, sponsored by the Durham Council on Alcoholism, is scheduled for February 9 and 10 in Durham. The conference will also serve as the annual meeting of the Flynn Christian Fellowship Houses which provide homes for homeless alcoholics who seriously seek help. The original Flynn home was opened in Baltimore, Maryland several years ago. The movement has now spread to six states. At present North Carolina has three Flynn homes—located in Durham, Charlotte and Fayetteville. Donald E. Macdonald, M.D., and Norbert L. Kelly, Ph.D., medical and associate director of the NCARP, respectively, will participate on the program of the two-day conference.

RALEIGH, N. C.: Dr. Norbert L. Kelly, NCARP associate director, recently returned from New York City where he attended a meeting of the executive committee of the North American Association of Alcoholism Programs. Dr. Kelly is Second Vice-President of the organization and chairman of the publications committee. While there, committee members met with representatives of the Smithers Foundation who gave the NAAAP a grant to establish a central office either in Washington or Chicago. Members of the committee also met with representatives of Alcoholics Anonymous and the National Council on Alcoholism and drew up a program for the annual meeting of the Association to be held in Bismarck, North Dakota this fall.

ABERDEEN, N. C.: Three programs for prison department personnel in this area, including guards, supervisors and other staff members, will be held January 23-25 in Aberdeen. Mr. George Adams of the NCARP and Mr. Joe Pinkston, assistant supervisor of alcoholic rehabilitation in the North Carolina Prison Department, will participate on the program of the three-day conference.

CHAPEL HILL, N. C.: The Orange County Council on Alcoholism will sponsor a two-day forum on alcoholism in Chapel Hill March 8 and 9, according to Mrs. Margaret Rollins, executive director. The schedule of events will include a session for Orange County ministers to be held at the Presbyterian Student Center at 1:00 p.m. on March 8 with the Reverend Jody Kellermann of Charlotte, executive director of the Charlotte Council on Alcoholism, as speaker. At 8:00 p.m. on the same day, Mrs. Marty Mann, executive director of the National Council on Alcoholism, will address a public meeting to be held at Hill Hall. On Friday, March 9, a dutch-treat luncheon will be held at the Carolina Inn for all who would like to attend. The concluding session of the forum will meet at 3:15 p.m. in the Town Hall where Mrs. Mann will talk with law enforcement officers.

RALEIGH, N. C.: The NCARP and the University of North Carolina School of Public Health are planning a summer conference on "Youth and Alcohol" to be held July 23-25 at the Episcopal Conference Center in Southern Pines. The program is being planned for local alcoholism program personnel, public school officials who have attended the Yale Summer School of Alcohol Studies, and selected public health nurses.

DURHAM, N. C.: The North Carolina Mental Health Association will hold its annual meeting at the Jack Tar Hotel in Durham on Friday and Saturday, February 16 and 17. "Action For Mental Health" will be the theme of the two-day session. A highlight of the meeting will be the association's annual banquet on Friday night. Speaker for the occasion will be Dr. Curtis Southard, chief of the Community Services Branch of the National Institute of Mental Health, of Washington, D. C. Another feature of the meeting will be a panel discussion on "Interagency Communications For Better Mental Health."

RALEIGH, N. C.: NCARP associate director Dr. Norbert Kelly and educational director George Adams have recently been working with officials at Saint Andrews College in Laurinburg, N. C. in planning a series of twelve orientation programs for the students of the college. The series will begin in February and will be conducted by Dr. Kelly and Mr. Adams. Topics of discussion will include alcohol, alcoholism and related problems.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

TENSION IN Alcoholics

BY D. G. STEWART

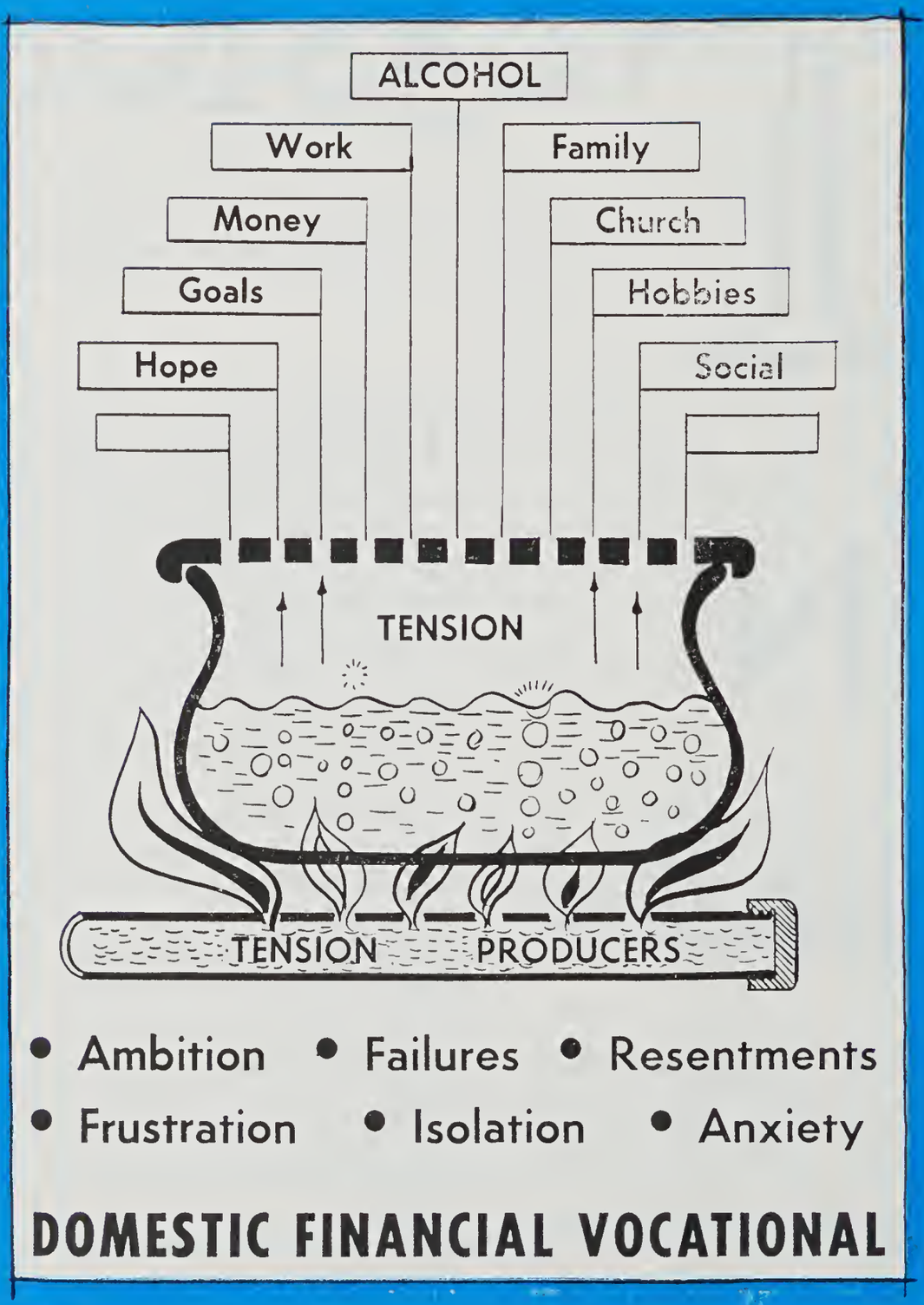
The alcoholic gradually loses the ability to handle tensions through "normal" outlets and learns to rely on alcohol for relieving pent up pressure.

TENSION is a necessary part of our existence. It gets us up in the morning, gives drive and purpose to our activities, helps us accomplish tasks and objectives and fulfill our responsibilities as social beings. Within reasonable limits, tensions are vital and worthy allies. People with too little or too much tension develop problems of many kinds.

Tension plays an important role in the life of the alcoholic. Most alcoholics have excessive tension. The reason for this is not fully understood. Dr. M. Freile Fleetwood suggests that alcoholics can obtain a greater degree of tension reduction by the use of alcohol than non-alcoholics. One can presume that the alcoholic learns to handle his tension in this easy, quick, reliable and effortless manner. Recovery from alcoholism must take this learned behavior into consideration.

All who have worked with alcoholics are aware of the tremendous tension most of them feel when they apply for treatment. It is important that the therapist help the patient understand something of the general nature and function of tension in addition to determining ways of relieving it.

"Tension in Alcoholics" is reprinted by permission from Progress, a publication of the Alcoholism Foundation of Alberta. Reference: Fleetwood, M. F.: Etiology of Chronic Alcoholism. Springfield; Charles C. Thomas; 1955.



- Ambition
- Failures
- Resentments
- Frustration
- Isolation
- Anxiety

DOMESTIC FINANCIAL VOCATIONAL

Everyone is constantly being bom-
ded by new stimuli which create
sion; so we must have a way of
lining off this accumulating ten-
n. Our ambitions, frustrations,
cesses, failures, and many other
ly experiences build up tension or
essure. This pressure motivates
ivity, which uses it up, thus pro-
cing a feeling of satisfaction. Much
this activity is channeled toward
cially approved goals and personal
hievement.

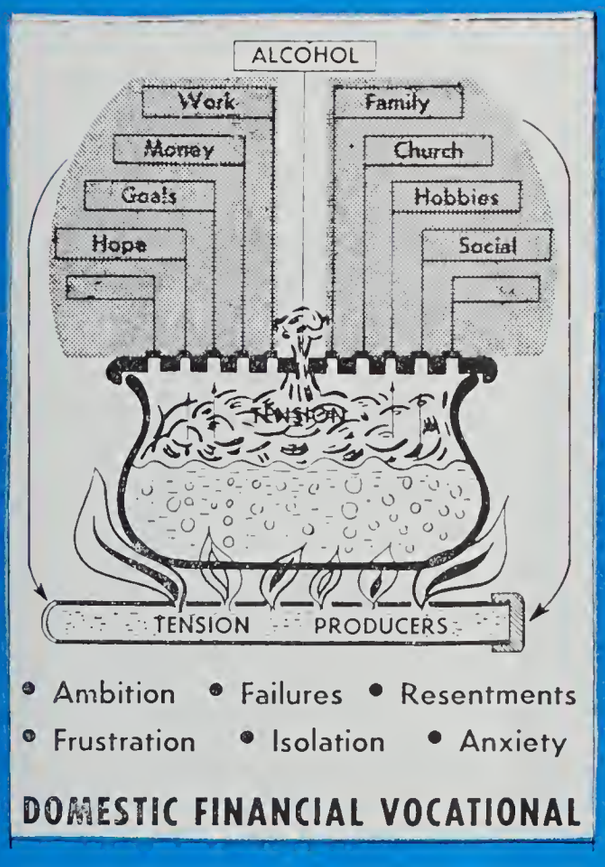
At the Foundation we have de-
loped a simple illustration of how
nsion is built up and dealt with.
e have found the chart a useful
ol in helping patients to under-
and tension production and reduc-
on and in explaining to them why
ey experience such intense distress
hen they quit drinking. In addi-
on, this visual aid has been most
fectively used in illustrating to
cial workers and nurses why the
coholic has such difficulty in giv-
ing up drinking completely.

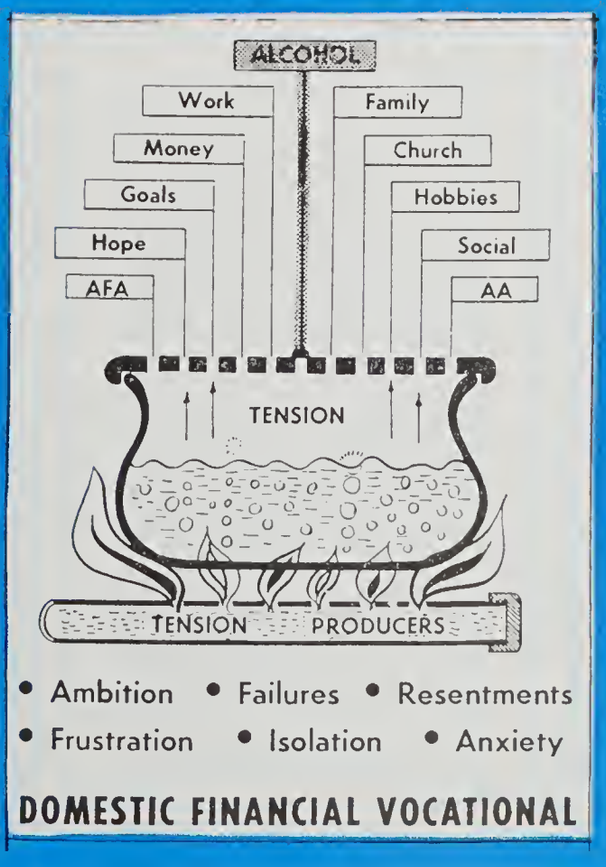
We make an analogy between a steam boiler and a human being. The fuels for the fire are the life situations which produce tension. Some of these are internal, such as failures, resentments, isolation; and others are external, such as problems within the home or on the job, involving other people.

The fire heats the boiler and the pressure inside grows. We learn to release this pressure through various outlets representing satisfactions—Hope, Goals, Work, Family, Church etc. Thus a tolerable and useful level of tension is maintained.

The potential alcoholic uses similar tension outlets in the same way. As his disease slowly develops, the alcoholic loses satisfactions and his tension outlets gradually narrow down until eventually he is left with only one method of relieving pressure—alcohol.

For example, much of our social





drinking occurs on Saturday nights. The potential alcoholic may have been a regular Sunday church goer. As his drinking increases, so will his Sunday morning hangovers. His attendance at church will not have the same satisfaction for him with a hangover, so eventually he will give up going to church. The tension reducing activity or outlet, church, is closed.

As the developing alcoholic drinks more on increasingly frequent occasions, the tension relieving social activities are threatened. If he finds that, regularly, he is having to telephone his host or hostess of the night before to apologize for his condition and behavior (sometimes without really remembering what happened), then such social activities are no longer satisfying. They themselves become a source of tension. A feedback develops, wherein many former tension reducers become tension producers. So the potential alcoholic now finds that he has increasing amounts of tension with decreasingly fewer effective outlets.

Sources of Tension

Let us suppose that the potential alcoholic's favorite hobby is spectator sports, and like many others in the crowd, he never goes to a football game without a flask of whisky in his pocket. Sooner or later he may drink so much at a game that his intoxication and aggressiveness attract the attention of the police, who warn him not to be seen drinking at a game again. Another satisfaction is lost and becomes a source of tension.

More tension producers mean more fuel for the fire and so an enormous head of pressure is being built up, with but a few escape outlets. He is spending more and more money on liquor. Money becomes a problem and no longer a provider of satisfaction in terms of what it might buy or what he can do with it.

The alcoholic's goals now become less well defined due to his increasing problems and he starts putting off until "next year" many personal and family responsibilities. His family becomes increasingly exasperated with the alcoholic's dependence on alcohol. Soon family problems outweigh family satisfactions. His family members learn that they can no longer depend on him and frequently exclude him from their plans and activities. Isolation adds more fuel to the mounting flames.

The alcoholic will strive to make it appear to the outside world that all is normal. He may flop as soon as he gets home, but on the job he is determined to appear as a staid and steady person who occasionally drinks too much. The cost in maintaining this front at work is taken out in a number of other areas. Gradually, however, he begins to lose control of this part of his life as well and work provides less and less satisfaction. He finds more and more to complain about at work. He will still tenaciously hold on to his job, but since he is getting no satisfaction from it and it is instead becoming a source of tension, another outlet is blocked and the pressure increased.

Finally he is left with two outlets —alcohol and imagination. The point will be reached, however, when he is so sick and shaky from a drinking bout that even hope and phantasy are beyond him. When he begins to feel *hopeless,* then his situation is truly desperate.

The alcohol valve is no longer just one of many valves as it was at one point in his life; it is now the emergency valve. Unless he opens it frequently, he will blow up with the tremendous pressure within him.

Sooner or later the alcoholic realizes that alcohol itself has become a contributing tension producer and

so he does the natural and normal thing under the circumstances and that is to cut off the alcohol. Now he has no method by which he is able to gain any satisfaction or relief from the pressure. Like a steam boiler, a person can handle only so much pressure before exploding. With the alcoholic, he explodes back into further drinking. One only has to observe the alcoholic in a drinking session to see the pressure being released. Frequent crying, loud shouting, fights, valiant attempts to do impossible tasks appear to indicate the tremendous internal struggle that is going on. So the alcoholic learns that stopping drinking is neither easy nor does it seem to be the answer to his problem. Thus far in all his experiments he has found it of no real help to give up the one resource he has which will give him some relief from the acute physical and emotional pain which he experiences.

Different Relationship

When the new patient seeks treatment and it is suggested that he not drink for a period of twenty-four hours, he is usually somewhat dumbfounded as he knows that this is no answer to his problem. However, something new has been added. With that first interview with the counselor, he find himself in a different type of human relationship than he has experienced before. He finds someone who understands, to some degree at least, how he feels and in whose knowledge and ability perhaps he can put a little faith and trust.

What is happening in terms of the steam boiler is that a new outlet has been opened. The patient finds that just being able to tell someone how he feels takes off some of the excess pressure which in the past has always caused him to explode. As he is able to gain more trust in his counselor, he is better able to handle this tremendous pressure since more of it is now being drained off. All patients coming to the Foundation are encouraged to develop an AA contact, which can also be a pressure outlet. Now the patient has two ways of handling pressure: thus recovery begins.

If the patient is working, he begins to do a better job and, perhaps for the first time in years, gains some satisfaction from his work. If he is not working, then the very fact of getting out and seriously looking for a job brings some level of satisfaction in itself.

We now enter a dangerous period. Alcoholics tend to be excellent workmen and, therefore, find a great deal of satisfaction from their work. Many patients are tempted to stop their program of recovery after opening the three valves of the Foundation, AA, and work. The danger is that the patient can get so engrossed in his work situation, working long hours, that he feels unable to keep up with his treatment contacts. If he allows himself to be boxed in again, he is endangering his sobriety. Work and work alone will not provide that much satisfaction.

Recovery from alcoholism demands that the patient continue a program of expanding out and opening up one after another of the various avenues of relief from tension. The tension is there; it is real; it is there in apparently larger quantities with the alcoholic than with the non-alcoholic. The alcoholic has learned to handle his tension in the past by drinking. Drinking has itself become a tension producer, so he has to re-learn or create other tension outlets. In this way, he is able to bring the pressure down to manageable quantities, with which he can live comfortably and constructively without alcohol.

An attorney speaks his mind about the legal profession's record in efforts to understand and help alcoholics and makes suggestions for its participation in the crusade.

"Can We Permit Justice To Remain Blind?"

BY ALBERT B. LOGAN

This article was originally an address delivered by the author, an attorney, at a joint session of the Law Society of England and the American Bar Association. Reprinted by permission from A. A. Grapevine.

ASSUMING—but, of course, not asserting—that all of you in attendance indulge in the use of alcoholic beverages, at least seventeen of you in this audience now are or will become alcoholics. Which individuals are alcoholics and which are not, I do not know, nor do you. You cannot distinguish them just by looking. However, that revelation is of some reassurance to me because I know that at least *that* many of the lawyers, judges, barristers and solicitors in this room have a genuine personal interest in the subject I have come here to discuss today.

My initial objective is to offer support for this proposition:

A lawyer without an understanding of this grave illness, alcoholism, is in the same dilemma as a surgeon without an understanding of anatomy. More than 5,000,000 of our fellow citizens in the United States today are afflicted with it. Unlike most other illnesses, this sickness wreaks its devastation upon those who are associated in any way with the alcoholic. Consequently, it has been reliably estimated that 20,000,000 other Americans are adversely affected by the illness of alcoholism.

A prominent physician in the field of mental health has said, "If alcoholism were a communicable disease, a state of national emergency would be declared!" Every lawyer in this room can cite instances, close to his family or professional life, of the loss and tragedy attributable to this disease. You must be aware of the appalling suicide rate among these people. But how many of you know the difference between an alcoholic and a drunk? If you do not have a genuine understanding of this illness, there are 25,000,000 American clients whom you cannot properly serve. And as a member of this great legal profession of ours, what are you doing?

Let's face the reality of the situation. Actually, lawyers have exhibited a strange reticence to bring this problem of alcoholism into the open.

We are told by the leaders in this field that the greatest deterrent to a solution of this problem is public apathy and ignorance. They say that until the stigma of alcoholism can be removed from public attitudes, no real progress can be expected.

Why does this stigma persist? In my opinion the stigma of alcoholism is being perpetuated by two influential facets of our society. They are: (1) The churches, many of whom persist in the bigoted view that the sick alcoholic is a moral leper, and (2) the legal profession, by and through whom an historically worthless penal approach by law is nurtured and preserved. (I refer to the punishment of the alcoholic as a criminal offender, or his classification either as a lunatic or as a person who is mentally ill.) It is true that such punitive measures satisfy the wish of our society, generally to get these unfortunate creatures removed from public view—and, thus, from the public conscience.

Legal procedures, punitive laws and police handling only aggravate the problem. Judge Murtagh has repeatedly declared that the penal approach to the problem is a national disgrace! Alcoholism is the only illness you can have for which society will send you to jail! Many get life sentences—thirty days at a time.

Antiquated methods of handling this problem are accompanied by a colossal waste of public funds. The City of Denver annually expends the sum of $1,300,000 just for the arrest, trial and incarceration of inebriates —without any pretense of offering any treatment or rehabilitation. Denver does a magnificent job of maintaining and expanding the sub-standard culture of its prospering Skid Row. If Skid Row habitues had their own chamber of commerce, they wouldn't ask for anything Denver is not giving. But since Skid Row alcoholics probably represent less than *three per cent of America's alcoholic population (and only about fifteen per cent of those on Skid Row are actually alcoholics) our thinking today should be directed to the ninety-seven per cent who are still existing in ordinary social environments.

Among this ninety-seven per cent are your clients and mine, your friends and mine, your neighbors and mine—business executives, judges, barristers, doctors. Alcoholism recognizes no class, makes no distinctions. Many of these are "hidden" alcoholics who are not known as such to public authorities or to their associates generally. And it seems quite probable that half of our alcoholic population is of the female variety. The fact that they are in the home and are commonly "protected" is the reason this fact of life is not generally considered.

In the January, 1960 issue of *Fortune Magazine*, the Executive Di-

**Authoritative estimates on the percent of Skid Row alcoholics range from 3 to 10.*

rector of the National Council on Alcoholism was quoted as saying, "Alcoholism all too frequently strikes the most promising member of a family, a school class, or a business. Granted that it also can strike the dull, the mediocre and the misfit, nevertheless the man susceptible to alcoholism very often seems to be the man who is a little more alert, a little better at his job and a little more intelligent than his fellows in his particular social, economic, or job level. He is more sensitive than the non-alcoholic, more imaginative and more aware, and he hates routine. The qualities that make an executive also characterize alcoholics."

History records the role of leadership provided by lawyers in all great political and social movements. Is our profession no longer fulfilling its mission in society?

Part in Crusade

My mission here today is to outline the part in this crusade that the American Bar Association is qualified to perform, within the dignified traditions of the organized legal profession. Here are some suggestions and recommendations as to what the American Bar Association could do:

1. Recognize that alcoholism is an illness and that the penal approach to alcoholism is fundamentally and morally wrong.

2. Acknowledge that the problem of alcoholism is of national concern.

3. Recognize that the matter of alcoholism is so involved with most other problems faced by the lawyer in practice, that it is now essential that he make a study of the nature of the illness and the available facilities for care and treatment.

4. Announce that education on alcoholism is an essential ingredient of law school education.

5. Urge the Senate Subcommittee on Health, Education and Welfare to provide an appropriation for a new Bureau of Alcoholism Control.

6. Establish in the framework of the American Bar Association a permanent Committee on Alcoholism with a directive to coordinate its activities with the work of the American Medical Association, the American Hospital Association and the National Council on Alcoholism.

Along the path of freedom and justice, we have found few human beings more cruelly oppressed or more enslaved than these unfortunate fellow-citizens we call "alcoholics"—human beings chained against their will to a compulsive addiction, degraded and despised by ignorance and bigotry, and relegated to the category of outcasts and outlaws; alcoholics whose acute pain and suffering is characterized by our medical profession as the most excruciating pain of all the ills of mankind known to medicine.

Sparked by the thought-shattering revelations of the great Fellowship of Alcoholics Anonymous—that this incurable malady can be successfully arrested and that the alcoholic is a person worth saving—the resources of physicians, psychiatrists, psychologists, sociologists, penologists are participating in this grand new adventure to improve the plight of man. Conspicuous by its absence, is the legal profession. In this situation, how much longer can we permit Justice to remain blind?

We know not when this tragic illness will strike close to any of us—our wives, our children, even we ourselves could be its victims tomorrow. Hence, if ever we were moved to invoke the practice advocated by the Man of Nazareth that ". . . whatsoever ye would that men should do to you, do ye even so to them . . ." this great avenue for service presents that opportunity.

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having enough insulin. There may be epilepsy not associated with alcohol, which is often followed by sound sleep for thirty minutes or so. There may be a real stroke—a blood clot in a big blood vessel in the brain. It may be a form of kidney failure called uremia.

All of these are things that must be considered when you see a person unconscious on the street. Instead of thinking, "there is another drunken bum", you had better start thinking, "there is a sick man that is in an emergency state and we have to do something about it." He is *sick* whether he is drunk or whether he has one of these other conditions.

In summary, how do you handle alcohol problems? From the medical standpoint, we should first realize that the patient is sick whether he is sick from some real organic disease or whether he is sick from the disease of alcoholism.

Second, it should be determined whether he is in such a state that he is going to hurt himself or hurt others. If he is, he must be locked up or at least protected.

Third, if he has to be put in jail, the degree of intoxication should be determined and he must be watched because he may have consumed a large quantity just before you saw him. This means that you must check on the patient frequently for the first few hours to see whether he is getting deeper into coma, or whether he can be aroused.

Fourth, in any kind of coma condition where the patient can't be aroused, and where it seems that he is getting deeper into coma, you ought to call a doctor or try to get him to a hospital. You can't afford to take that responsibility on yourself. It may be alcohol or it may be something else. If the coma lasts longer than a few hours, there are probably more complications than just alcohol because by that time the patient will have usually elminated enough alcohol so that he can be aroused.

Fifth, if he has true D. T.'s, of course, you must call a doctor.

Sixth, you should at least be aware of the possible complications of alcoholism.

In Memoriam

DAVID S. Godfrey, supervisor of alcoholic rehabilitation in the North Carolina Prison Department, departed from this earthly life January 7, 1962.

Mr. Godfrey came to the prison department from Salisbury in September of 1957 with a mission—to establish Alcoholics Anonymous groups in prison units throughout the state—and an abiding faith—that every little bit of help an inmate received in prison would improve that man's chances of leading a sober and satisfying life when he got out. His job wasn't easy. There was no pattern to go by. He had to begin by "feeling his way." But David Godfrey was undaunted. His faith and enthusiasm never wavered, even in the face of personal ill-health.

His task was made even more difficult because the state's prison units are scattered far and wide. He was always traveling somewhere—setting up new AA units; constantly endeavoring to strengthen those already established; soliciting the aid of professional people and "outside" AAs in visiting the AA units and participating in the prison AA program.

Through his untiring efforts there were twenty-eight active AA groups in prison units at the time of his demise. He was truly a dedicated man, devoted to his mission of helping alcoholic inmates. His presence will be greatly missed; his memory, an inspiration to those whose task it will be to continue and expand the work he began and to which he gave so much of himself, so devotedly, so freely.

Social Implications of Alcohol

BY RAYMOND PAYNE, Ph.D.
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What a person does about drinking depends upon the alternatives made available to him by his culture.

Dr. Payne's article is a part of the published proceedings of a regional conference on "Developing an Effective Alcohol Education Program in the Public Schools" held at the University of Georgia Center for Continuing Education in Athens and financed by a Technical Assistance Grant from the USPHS. Reprinted by permission of the author.

THE matter of alcohol, its consumption, and its consequences in society, has recently become the object of considerable speculation and research among sociologists. It is perhaps significant that they are coming to bring their theoretical guns to bear upon this matter at this time, because this will mean another branch of science might be able to add something to the accumulating body of understanding currently emerging as psychologists, biologists, geneticists, nutritionists and many others are producing leads and hunches on their own and in cooperation with each other. Sociologists are, of course, strong consumers of the findings of others and, in turn, hope that any and all interested groups and persons will find sociological findings useful in their own endeavors.

For the next few minutes I shall array some materials as examples from our standard sources. From time to time I shall pause to point out some of the directions that future investigations might take.

First, a few words about the "sociological approach" to alcohol and alcoholism: regardless of whatever personal values the individual sociologist may hold regarding alcohol, he is obligated as a scientist to observe and study behavior and to report his observations without bias, just as any other scientist is so obligated. Therefore, the sociologist is not trying to sell anyone anything; therefore, you need not feel compelled to buy or refuse to buy anything. The sociologist is simply in the business of learning about social behavior and making his findings available to all who are interested and who may find them useful.

To study anything, that thing must be conceived of in some manner. How shall we conceive of alcoholism? (I shall use this as a general, rather than a specific term, unless otherwise stated or indicated.) We might conceive of it as a sin, but the demonstration of such is clearly outside the realm of sociology, with its scientific orientation. We might conceive of it as a problem, as recreation, or something else.

First, let's see if it qualifies as a social problem, and for this purpose we can look at a set of statements

with which most of you are probably familiar, but may also be worth repeating.

Americans spend more money for alcohol each year than they spend upon education of their children.

The direct economic cost of alcoholism in the United States is estimated at one billion dollars per year alone.

An estimated two-thirds of all adults drink, some 60-80 million people in the United States.

The best estimates available indicate a pool of 4 to 5 million problem drinkers out of the total 60-80 million drinkers.

Most of these 4 to 5 million people would be termed chronic alcoholics.

Approximately 13,500 of them are the victims of alcoholic psychoses.

Over 200,000 people are arrested by the police each year and charged either with drunkenness or disorderly conduct—more than five times the number charged with gambling, drug addiction, and prostitution combined.

One hardly needs to comment at this point on the problem aspect of the situation—one has simply to visualize the police and courts in their continual dreary preoccupation with the endless process of running the drunks through the rituals of legal procedure (at public cost of course!) and secondly, to visualize 13,500 Americans disabled and maimed by psychoses resulting from alcohol, their ailments otherwise preventable, it is assumed, to come face to face with the social problem idea.

But why, we say, will people do that which will cause them to become objects of police action or cause them to lose their mental capabilities? Why, indeed, and what can sociologists add here that is not already explainable in biological or sociological terms? Perhaps more than some might think.

Let's look at some of the PATTERNS of alcohol. First, drinking is recognized as a regular part of American culture; some don't survive, and it costs a lot. Automobile driving is a regular part of American culture; some don't survive, and it costs a lot. Hunting costs a lot and some don't survive, and the same could be said of golf, smoking, and many other things. Let's look at it, then, just as we might examine any other regular part of the culture, and

see what might turn up.

Since drinking is recognized as a regular part of the American culture, one need not look for aberrant personality factors or unresolved frustrations to explain why most people begin to drink. A recently completed study of the drinking habits of over 15,000 college students indicated that 80 per cent of the men and approximately 60 per cent of the women engage in some kind of drinking. Moreover, the study reveals that knowledge of the students' backgrounds and their present social situations provides some basis for predicting how many of them will be drinkers, what they will drink, and how much and how often they will drink. The probability that an individual will imbibe apparently is greater if he attends a private non-sectarian college, if his family has a substantial income, if he does not belong to the Mormon church, and if his parents drink, and if his close friends drink. Moreover, most of the students who are drinkers began before they entered college, and took their first drinks in their own homes. As you know, such studies do not show much excessive drinking later in life. However, when one's drinking has begun, there is always the danger that it will get out of hand; about 90 per cent of diagnosed alcoholics began as social drinkers, and later lost control over their drinking; only ten per cent started as solitary drinkers. Therefore, it would seem that the groups to which a person belongs, and the norms, standards, and the standardized attitudes and procedures in those groups are the dominant factors in drinking or not drinking.

If the group influences are indeed dominant, then clearly here is sociological grist for the mill. Let's look further:

What people drink, where, when and in what quantities, depends upon the social context. Beer, wine, whiskey, bourbon, scotch, and brandy have different appeals at different social levels. In some groups men drink with men; in others men and women drink together. In one situation the goal is to get rapidly and boisterously drunk; in another, two drinks before dinner are usual with three or four drinks after dinner. Certainly "well-bred" people do not become intoxicated—that is, too intoxicated!

AA's Success

There appear to be sound sociological reasons for the relative success of Alcoholics Anonymous. In Alcoholics Anonymous the alcoholic finds a group in which his affliction does not stigmatize him, but is actually the means of his gaining status and group support. He maintains and increases his status by "staying on the wagon." In the meantime, he gains a sense of personal worth by helping others, and has a new and absorbing pattern of activity to use up the energy that formerly went into seeking alcohol. In fact, these factors for group identification and group support may be more important in accounting for A.A.'s successes than are the formal propositions to which A.A. members subscribe.

We will now pursue this social-cultural approach somewhat further.

Alcoholism is much more of a problem in some societies than in others. In the United States, where alcoholism is a serious problem, Jews have a very low alcoholism rate. Only 13 per cent of Jews as compared to 21 per cent of Roman Catholics and 41 per cent of Protestants are teetotalers; moreover, Jews drink more regularly than either of the other two religious groups. But, judging from admis-

sions to hospitals for alcoholism, Jews are almost completely out of the picture. Mormons in the United States ban the consumption of alcoholic beverages altogether and experience almost no alcoholism. (Let us return to certain of these considerations at a later point.) Apparently more Canadians than Americans drink, but the alcoholism rate is twice as high in the United States. France has an extremely high alcoholism rate, but in Italy, despite almost universal drinking, the alcoholism rate is very low. Among the Aleut Indians, heavy and extended drinking appears to result in no true alcoholism and there are practically no guilt feelings associated with drinking or drunkenness. Thus, both the use of alcohol and the incidence of alcoholism vary widely over the world, and appear in varying relationships to each other.

Drinking and Culture Patterns

Clues to the reason for this extreme variability can be found in the way in which the drinking patterns fit into the over-all culture patterns. Where drinking is associated with manliness and virility—as among the Irish, the French, and even in the United States—alcoholism appears to be common, the Jews and the Mormons, on the other hand, appear to have strong taboos against excess—and have very little alcoholism. Among the Italians, drinking appears to fiit into the nutritional patterns and, unlike the French, the Italians do not often drink apart from their meals. It has also been suggested that alcoholism is more common in countries with a strong Puritan ethic. Thus, where the social group withdraws its approval from drinking, it becomes either a solitary vice or an act shared covertly with a few companions. The alcoholism rates of Sweden and the United States, both of which have tried prohibition, are among the world's highest.

Tentative as they are, the hypotheses growing out of such observations, based on cultural and social factors in alcoholism, seem more promising than those which seek causal explanations in physiological and psychological differences. As Robert Faris says in his book SOCIAL DISORGANIZATION: ". . . we call a man a social animal. He doesn't have the ability of a salmon, to hatch from an egg and make his own way in life. He requires a supporting organization of the type which is called a family to feed and care for him in infancy and to teach him the basic knowledge of house physics and mechanics—such lessons as the avoidance of stoves, the perils of falling from stairs, the fragility and cutting power of glass, and the like—and to give him language and the basic social sentiments and customs. He requires a school system to educate him, a law-enforcement system to protect him, an immensely complicated economic organization to supply material goods in life, a governmental structure to coordinate these, and a variety of organizations for other specific purposes."

If this be the nature of man—that he is dependent upon social organization for the satisfactory formation and functioning of personality—then is it not logical that he is dependent upon social organization for support and direction in the matter of alcohol? Actually, not only is this conclusion logical, it is indeed inevitable! Therefore, to find causal factors in the satisfactory or unsatisfactory handling of the matter of alcohol by individuals, is it not necessary (and not simply desirable) to look at the social organization within which people are functioning, and NOT simply "at" or "inside" individuals?

When we look at the social organ-

izations within which people are functioning, we may find inconsistencies or contradictions, evidence of faulty social organization, or that a particular set of customs and cultural elements fits together so that individuals are likely to experience frustration or other damaging situations. The rules and values of a culture influence and redirect the expression of deeply motivated behaviors and even the forms of individual maladjustment, and as an illustration of this, we can use as a "case in point" a combination of some points mentioned earlier—the social organization and the alcohol facts about three sub-groupings within American society—Orthodox Jews, Anglo-Americans, and Mormons.

For Orthodox Jews (the most religiously conservative of Jews) drinking is a normal part of everyday life. The practice is learned from early childhood in the family circle and by all members of the group. It is highly regulated, and deviations are severely sanctioned. The function of drinking is to draw the group together in intimate association of family and friends, and there are strong religious overtones. Almost everyone drinks, but alcoholism is practically non-existent.

Among "old" Americans (persons at least three generations in America) of British Isles background, drinking alcoholic beverages is less clearly defined. It is learned in late adolescence, often within the peer group and sometimes secretly. It is accompanied by guilt, hostility, and exhibitionism. Instead of being supported by and in turn supporting group norms and standards, as among Orthodox Jews, drinking represents a relaxation of norms. The act is vaguely defined. Instead of being part of family life and other intimate associations, it is often done away from home and frequently in public places. Although drinking is far less common than among Orthodox Jews, there is a far higher incidence of alcoholism.

Mormons strictly forbid drinking. The very act is a defiance of group norms. Drinking is rare, but those who do drink show an exceedingly high rate af alcoholism.

Culture's Influence

The variations in the rates of alcoholism among these groups can not be explained by varying incidence of personal maladjustment. The kinds of things people do, either when they are normal or when they are psychologically disturbed, depend upon the alternatives opened to them by their culture. If alcoholism is low in one group, it does not follow that the amount of psychological maladjustment is correspondingly low. There is no evidence that Orthodox Jews are any less maladjusted than "old" Americans. Because the form that maladjustment takes is governed by culturally ingrained customs and values, the individual maladjustment of these Jews is expressed in other ways than through alcoholism. The same is also true for almost all Mormons, but in this case because their culture forbids the use of alcohol. The Anglo-American culture leaves much to individual choice and judgment, and alcohol is neither consistently forbidden nor regulated and ritualized in its use. The lack of consistent norms and practices in the use of alcohol probably increases the likelihood that it will be used in uncontrolled ways.

Thus we see that the same social structure and culture that in the main make for conforming and organized behavior also generate tendencies toward distinctive kinds of deviant behavior and potentials of social disorganization. In a sense,

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ON CREATING A CRISIS

The author suggests that it may be a good idea to help the alcoholic "hit bottom" as soon as possible.

BY HERMAN E. KRIMMEL

DIRECTOR OF CASEWORK SERVICES
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ONE of the most effective devices for arousing discussion in professional groups is to declare that "creating a crisis" in the life of an alcoholic may be an essential step in treatment. Among many practitioners in the so-called helping professions, it is almost an article of faith that the job of the therapist is to quiet the fears and anxieties of clients. If this procedure is followed with alcoholics, however, it may only mean the postponement of much needed help.

It is generally agreed that most alcoholics will seek help only when they hit bottom. For a long time it was assumed that bottom had to be a skid row flea bag or a cell in the county jail, but we are gradually recognizing the fallacy of that concept. Certainly, only a small fraction of the alcoholic population—possibly not more than 5 percent—ever reaches skid row.

The bottom is different for each individual. It is that point at which he says to himself: "I've had it. If this is what alcohol does to me, I'd better quit drinking."

One of our patients, for example, hit bottom when he realized that his teen-age daughter was not inviting her friends to the home because she was ashamed to let them see her father stretched out drunk on the living room couch. Another man hit bottom when he became aware of the fact that his son refused paternal invitations to football games because of the inevitable bottle and the embarrassing antics that followed too much guzzling.

Unfortunately, most alcoholics do not reach bottom quite so early or at such relatively "respectable" levels. While the loss of one job may provide the impact for some, it may require the loss of ten or twenty jobs or a slide to the relief rolls for others.

One patient, whose drinking was

limited to widely spaced episodes, decided that he always got into trouble on these occasions and never at any other time. During a spree he irresponsibly wrote checks to the order of almost anyone who asked. Girls in cheap saloons and proprietors of shady gambling joints were frequent beneficiaries of his unintentional charity. Sometimes he sobered up in time to notify the bank to stop payment but explanations were, of course, humiliating. He sought help before he suffered complete financial ruin.

The onset of blackouts and the terror that often accompanies the inability to recall where one has been or what he has done can be the bottom for some alcoholics. One patient went to his garage on the morning after a strenuous night. He was startled to find a parking ticket from a city fifty miles distant under the windshield wiper of his car. He did not recall driving to or from the city although a friend later confirmed the fact that he had made the trip. That was enough. He made an appointment at the Center on Alcoholism that afternoon.

Another patient, a successful sales manager, downed three martinis at lunch and returned to the office where he spent the afternoon dictating letters. During the next morning he began to dictate the same correspondence again. When his secretary pointed out the duplication—with documentary evidence—he realized that the afternoon of the previous day had been a complete blackout. At first he dismissed the experience as a freak accident, but after several repetitions he decided to obtain help.

The phrase "hitting bottom" is, of course, another way of saying that the alcoholic finally meets the crisis that makes him want to alter his behavior. This may not be pleasant for him but at some level it is apparently necessary. If that is true, it seems to follow logically that the sooner it happens the better. That is why it is so important for those in contact with alcoholics to help it happen if they possibly can.

A wife or mother may try to protect the alcoholic from such a crisis with the best intentions but her efforts are usually misguided. The alcoholic who is sheltered from the reality of his behavior has little reason to stop drinking. He continues to derive satisfaction (no matter how unhealthy) from his drinking and he does not have to face the consequences so why should he stop? The well-meaning spouse who calls the boss regularly to say that her husband has a severe cold or an upset stomach (common euphemisms for hangover) is only permitting a progressive illness to get worse.

One young woman, typical of many, purchased liquor for her husband because each time it happened he promised it would be the last. But, he pleaded, he could never endure this final weekend without a few drinks to subdue the shakes. The promise was repeated 52 times annually and as long as his devoted mate played the game his way there could be little genuine motivation to change.

A suburban couple had a 26-year-old son who drank himself into a stupor every Saturday night and was invariably found in an alley by the police who arrested him. Just as invariably his father, fearing community gossip, arranged his release after extracting a solemn vow that it would never happen again. But it always did. One night the youth tangled in a drunken brawl. This episode could not be concealed. Action became imperative and, luckily, culminated in successful treatment. It is possible, however, that some of

the difficulties might have been avoided if a crisis had been forced sooner.

Much of the work with the families of alcoholics involves the effort to support them in trying to compel the alcoholic to face the consequences of his behavior. This is not easy. There is always a calculated risk for these people because it is impossible to predict with certainty which crisis will provide the stimulus for a change. Sometimes nothing does. But if wives, parents or relatives want to help effectively, they almost always have to take some positive action.

Sometimes the action has to be drastic; sometimes it doesn't. In any case, many who could help are reluctant to take the necessary steps because this may appear to be a betrayal or desertion of a sick person at the time of greatest trouble. Nevertheless, action that may seem harsh at the moment may well prove to be the most constructive in the long run.

We are fully aware, of course, that such action is not always possible. A mother with four children may choose to cling to her alcoholic husband, no matter how miserable the circumstances, because of the terrifying uncertainties of separation even though that might precipitate a health crisis. If she does, she may have to wait for another type of crisis to arise—some bottom other than the loss of his family.

The choices for the non-alcoholic members of the family are often difficult. Sometimes they appear to be impossible. We do not know of any magic that can be performed. Coping with an alcoholic is always difficult. But experience has taught us that the alcoholic will seek help only when he hits bottom and that it can be helpful to raise that bottom to break his fall as soon as possible.

SOCIAL IMPLICATIONS

CONTINUED FROM PAGE 28

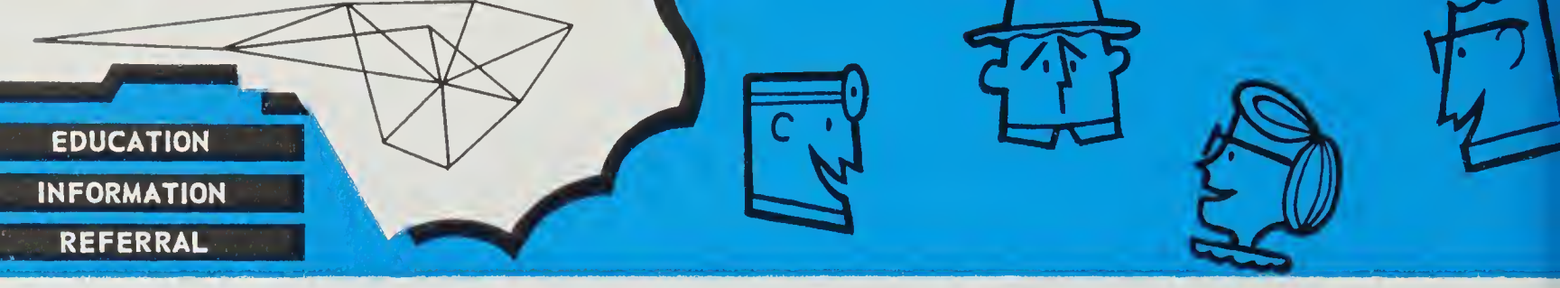
the problems current in a society represent the social costs of a particular organization of social life.

On this promise, then, it becomes necessary to reject certain statements of causes of alcoholism, and instead to search out the ways in which socially prized arrangements and values in society can produce socially condemned results. Also, to a substantial extent, social problems are the unwilled, largely indirect, and often unanticipated consequences of institutionalized patterns of social behavior, from which it would logically follow that in order to study and understand disorganization in particular segments of social life—such as alcohol—it is necessary to study and understand the social framework of their organization.

Solving Problems Difficult

This approach makes it easy to understand why finding and instituting remedies for social problems are so difficult. They invoke tinkering with and changing established culture patterns and values, as well as giving up some treasured conditions or values and, further, efforts to do away with one social problem usually give rise to other (either more or less damaging) problems.

Simply because difficulties can be, and have been, noted is no sign that we should abandon the attempt to remedy the situation with respect to alcohol, however. Probably the problem-less society, in which all is as each person would want it, is a fantasy. But it does not follow that public policy cannot result in the progressive curbing of particular social problems (such as alcoholism) and be the better prepared to cope with the new ones coming along.



Currently in North Carolina there are fourteen

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Sgt. Carrol R. Owens, Chairman
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary — Phone: 942-7253

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellermann, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
602 Snow Building
Mrs. Olga Davis, Executive Director — Phone: 682-5227

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
Rev. Edward Laffman, Director

LAURINBURG
Scotland County Citizens Committee on Alcoholism
308 State Bank Building—
P. O. Box 1229
M. L. Walters, Executive Secretary — Phone 276-2209

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

NEW BERN—
Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
Gray Wheeler, Exec. Secretary
Phone: 637-5719

REIDSVILLE—
Rockingham County Committee on Alcoholism
225 West Morehead Street, P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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VOL. 11, NO. 6 MARCH-APRIL, 1962

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

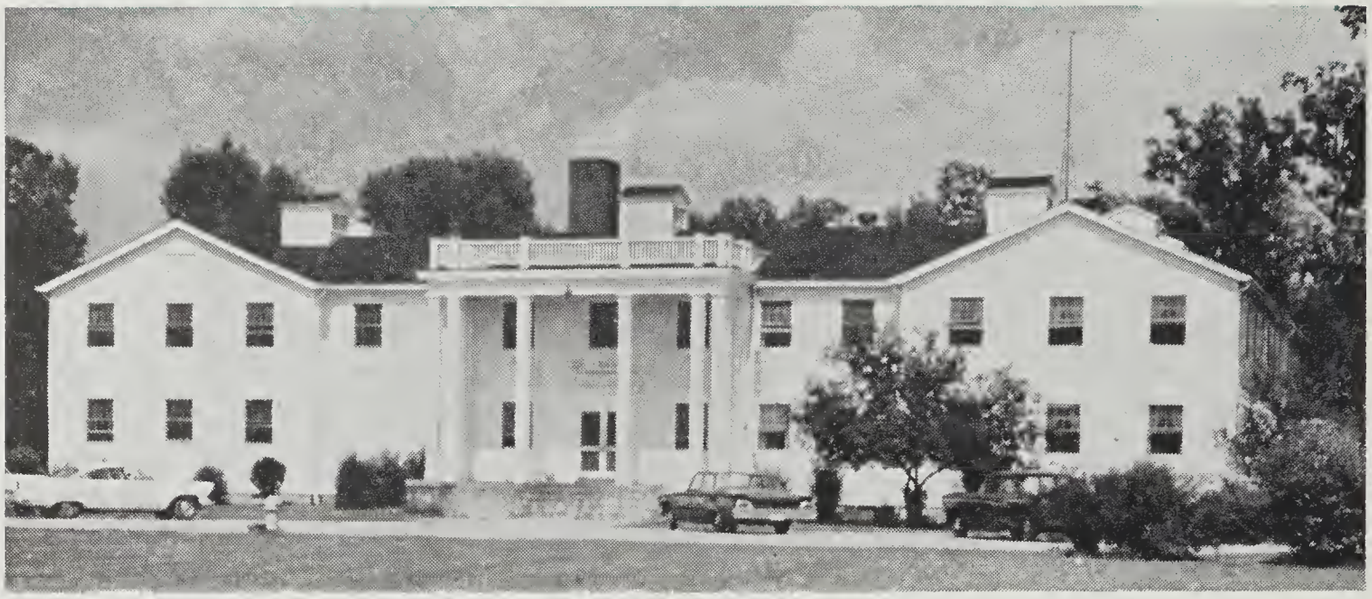
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehablilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 11 NUMBER 6

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RALEIGH, N. C.

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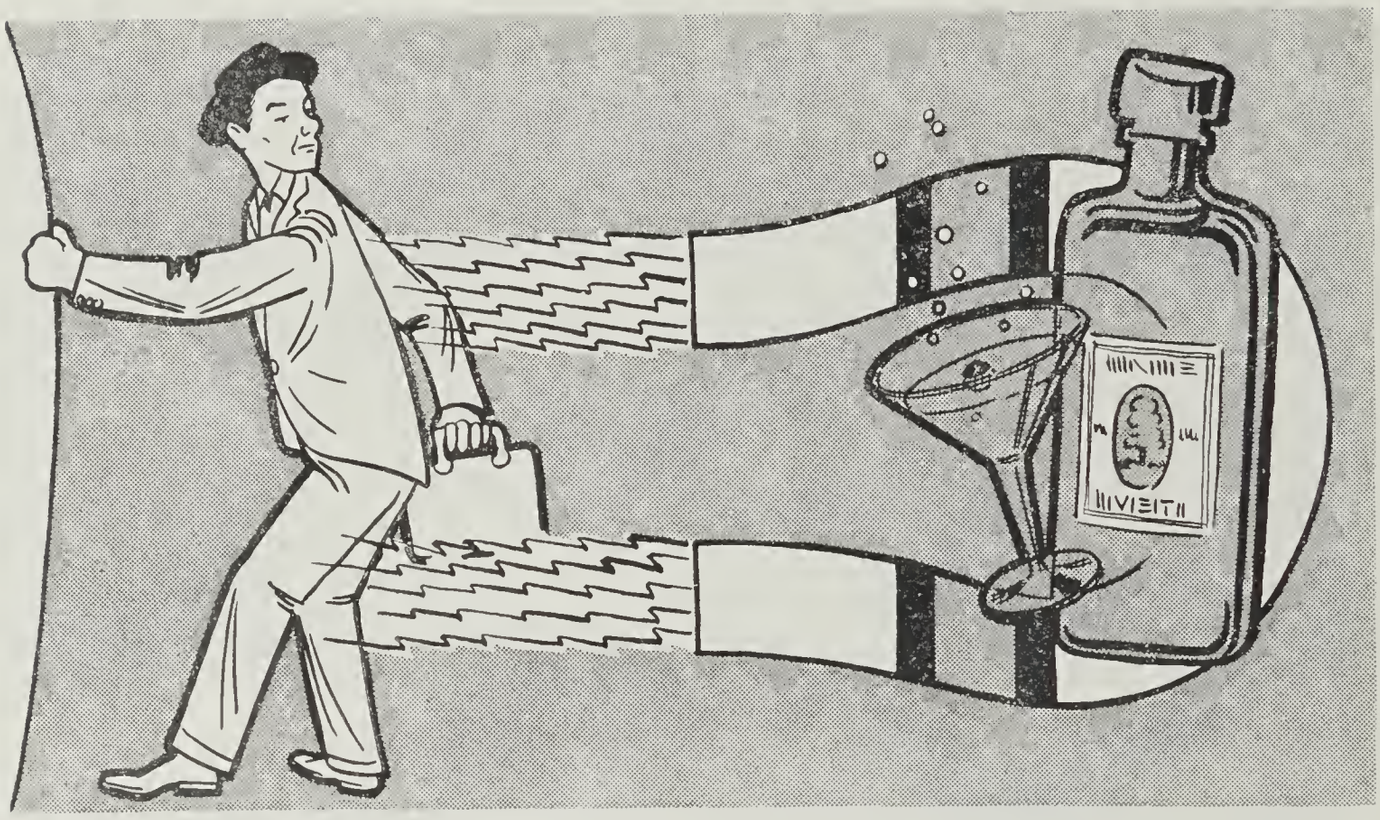


PROBLEMS OF ALCOHOL AND ALCOHOLISM

Society's Ambivalence

BY VERNELLE FOX, M.D.
MEDICAL DIRECTOR
GEORGIAN CLINIC ON ALCOHOLISM

Ambivalent feelings about alcohol and alcoholism exist in all of us from the most rigid teetotaler to the most accepting therapist, and particularly in the alcoholic.

ALCOHOLISM is a complex syndrome that is not totally understood. The addictive drinking is a symptom of the underlying maladjustment. It is the solution to the problem for the patient for years before it becomes a major problem itself. There is no such thing as "the alcoholic." There are several broad groups of alcoholics and innumerable personal variations within these groups.

At the present time, we classify this illness by the presenting symptom—the destructive drinking; but we recognize that this is only a classification of convenience. It is justified because the symptom within itself becomes so destructive to both the patient and society that it must be corrected before any attempt can be made to get at the underlying pathology.

This article, reprinted by permission of the author, was originally published in the proceedings of a seminar, "Developing an Effective Alcohol Education Program in the Public Schools," held last summer at the University of Georgia Center for Continuing Education in Athens.

The addictive drinking may be likened to an elephant's trunk; it is easily recognizable as such. But not only do elephants' trunks vary —they are only the presenting part of the whole; behind them can be an incalculable variety of elephants.

Similarly, this "cause" or mechanism whereby alcoholism develops is complex and not completely understood. Many factors play an important part in the development of addiction. It might well be likened to hash. Hash is a *blending* of many ingredients. The completed product does not taste or look like any of its ingredients but would not look or taste like hash without any of the ingredients. Some of the major components of the hash, alcoholism, are: the basic personal adjustment difficulty—ranging from mild neurosis through severe psychosis; the chemical nature of alcohol itself; society's ambivalence about alcohol; a struggle for control in sick interpersonal relationships; and possible physiological abnormalities.

It is the third of these factors that I wish to discuss—society's ambivalence about alcohol. By ambivalence I mean two or more conflicting *feelings* about the same subject. This ambivalence may extend into conflicting ideas or opinions as well, but the feeling conflict is of more importance. This ambivalence or conflict can be seen between individuals and/or groups of people but is of the most importance when viewed within any one individual.

Ambivalence about alcohol, or, more properly, drinking, and about the illness, alcoholism, or addictive drinking, exists in all of us, whether we are aware of it or not. This is true from the most rigid "teetotaler" to the most accepting therapist, and it is more specifically true within the patients themselves.

The first in the long series of these confusions exists between drinking itself and the illness, alcoholism. Most people experience considerable difficulty keeping the two issues separate in their thinking. Society and individuals have many problems—moral, economic, and legal, revolving around drinking and especially drunkenness. Such things as drunk driving, destructive behavior while under the influence, decreased sense of responsibility to oneself and others, and loss of sense of respect for authority are only a few of the vast number of problems that may be seen in association with excessive intake of alcohol. These are problems that have always been with us and will always be with us to some degree.

On the other hand, there is the illness, alcoholism. Over six million people in the United States today are trapped in a way of life that revolves around the ingestion of alcoholic beverages. These are sick individuals who are consumed by a slow growing cancer that is as deadly as any other known to the medical profession. Unfortunately, the two major problems—drinking and alcoholism—have one glaring aspect in common, drunkenness. Society in general has always been opposed to drunkenness and the irresponsible behavior that usually accompanies it. This is as it should be, but it is probably the only part of the whole question that even vaguely approaches consistency. Even this is not as consistent as it might appear on the surface. There is still a good bit of value placed on "wild" or destructive behavior by many subgroups and by most people at some point in their development.

Concerning alcohol itself—take an honest look at your own deep feelings. Alcohol is at once a lure and a threat—we're drawn to it and repelled at the same time. It is the

Student Writes

I am a student at St. Andrews College in Laurinburg. Right now I am writing a term paper on the effect of alcoholism on the family. I would appreciate any information you could give me.

Gail Pearson
St. Andrews College
Laurinburg, N. C.

AA Help

Permit me to thank you for myself and the AA group here for the issues of *Inventory* we receive. They have been of great help to us all. Our state is in the process of adopting a program on alcoholism. We in AA do not attempt to participate in the formation of this program, but stand by, ready to do what we can to help in any way possible.

Anonymous
Ellensburg, Washington

Help For Families

I am in need of some material to help the families of alcoholics to understand their part in the rehabilitation of the alcoholic. Please let me know what you have for this purpose. If you know of good material from other sources, I would appreciate that information, also.

Rev. J. W. Lineberger
New Bern, N. C.

Alcoholic Family Member

There is an alcoholic in my family and I am interested in learning how to handle this problem. Any information you have on alcoholism would be greatly appreciated.

Anonymous
Bessemer City, N. C.

Directory Wanted

Our students who affiliate at the Durham County Health Department are constantly confronted with problems of alcoholism in their "families." We would be most appreciative of a copy of the *Directory of Facilities for Alcoholics in North Carolina* and any samples of materials you feel might help them.

Elizabeth L. Watling
Instructor in Nursing
Duke University
Durham, N. C.

Alcoholics on Probation

I recently saw a copy of *Inventory* and feel it will supply much needed information on alcoholism and be of great help to me in dealing with alcoholics who are on probation under my supervision.

Leslie F. Eason
State Probation Officer
Rockingham, N. C.

Fine Periodical

A few years ago I requested that my name be placed on your mailing list for *Inventory*. I wish to extend my thanks for such a fine periodical, with articles written with intelligent understanding on alcoholism. When I have finished with each copy, I take it to our local AA group, to one of the groups in the state prison or the AA group at the state hospital. Your state of North Carolina is worthy of great praise for its fine program in treating alcoholics.

Anonymous
Middletown, N. Y.

"Old Granddad" of all tranquilizers. It eases the stress and tension of everyday living. It is the "fluid of the gods," the "giver of life." It has always been associated with celebration, grief, birth, betrothal, death. It is the seal of a brotherhood—a symbolic "blood bond" of contracts. We drink together to seal a bond or pledge.

On the other hand, drinking is "evil" or "sin." Vaguely we feel it symbolizes promiscuous sexual activity—looseness of moral standards, assorted dishonesties, etc. As Doc Blanding said, "We loathe while we love the thing—and that's the way one feels about sin."

The depth of this personal ambivalence is reflected in both our laws and social customs. It's almost ludicrous when you look at it. It is legal to buy whiskey on one side of a street and not on the other at county borders. It is legal to buy two quarts but not three—you have to go to another store to get the third. It's legal to sell a gin and tonic but not a martini—it must be diluted to less than 7% alcohol content. (This serves some purpose, I suppose, i.e., the heavy drinker gets plenty of water each day.) It's legal to carry a closed bottle but not an open one; so you have to drink it all up to stay within the law. The list could be extended indefinitely, but this paints the picture.

In more subtle ways these conflictual attitudes are reflected in our social customs. You're not a "he man" if you don't drink on Saturday night, and you're a "sinner" on Sunday morning if you did. So we have our cocktail parties and go to church —both activities we want and need. We resolve the conflict by refusing to discuss the two at the same time. Who ever heard a serious discussion of religious philosophy at a cocktail party, or the pleasures and sociability of a cocktail party discussed at a religious gathering?

One way to handle conflictual feelings is to try to ignore them. It doesn't really work—the feelings sneak out in many ways. Guilt feelings probably account for a large amount of both the telling of jokes about religious people at parties, and the vicious condemnation of drinking groups at religious gatherings.

If the ambivalences about drinking are this numerous and deep—those about the alcoholic patient are even more so. The plot thickens—we take all these ambivalences with us when we get to the subject of the sick addictive drinker. On the one hand, we are told and we intellectually accept—even emotionally accept, if we have ever lived close to a patient—the fact that the individual is ill. We know that he is in need of and deserves help but at the same time we're angry with him for frustrating us and causing us so much difficulty. We want to help but we're afraid of him. He makes us feel guilty because we don't know how to make him different or how to make ourselves feel better. Guilt feelings are painful; so to rid ourselves of them we get angry at him and blame him for creating such a mess in the first place. One of mankind's oldest reactions is: "If you don't comprehend it—condemn it." This reaction is nowhere more clearly seen than in relationship to addictive drinking—again both in law and custom and in individual reaction to individual.

We do not understand what is going on within the alcoholic or within ourselves about him. We are generally afraid of the unknown. Fear is painful. Have you ever watched animals? When they hurt or are afraid, they do one of two things—fight or hide. We are no different in this respect. For centuries

we have tried to ignore the problem as long as we could and then hit out at the patients. We do this collectively and individually.

At work we know ol' Joe is "hooked" on alcohol. We know that the reason he is always sick on Monday is his drinking. But, ol' Joe's a nice guy—we like him—so we cover up for him, do part of his job, and change the subject if it's brought up. We go along covering up for him right up to the time he loses his job. Helping him? Yes, helping him to "kid" himself right out of the best job he may ever have!

Maybe we do talk to him about his drinking—usually only if he insists on bringing it up. We can't completely ignore it so we try to make light of it. "Oh, Joe, you're no alcoholic, you're too nice a guy. You have too nice a family. You just gotta cut down on your drinking—you know, don't take but one or two, etc., etc." This is real "nice" advice, just what he wants to hear, but unfortunately he's not capable of following it. Who is it we are trying to reassure—him or ourselves? Are we really hoping that we're "too nice" to have to face the issue? Does being "nice" make reality any less real?

Ol' Joe's wife or teen-ager comes to us. It's the same song, with slightly different lyrics. "Oh, it will be o.k., honey. He's just sowing some wild oats; he'll be all right soon—don't worry about it." Don't worry about it? Don't be upset because your whole life is crumbling around you? That's like saying "think happy thoughts"—a fine idea but how do you do it?

We don't do this as individuals. We continue the hiding game as groups. No, we can't have programs on alcoholism in our churches, schools, or clubs. It might shock some members or maybe encourage some to try drinking or maybe just make us all uncomfortable because we had to think a little!

So, we go along trying to avoid the discomfort by ignoring the problem. But then it becomes so bad we can't hide from it—so what do we do? We fight. Whom do we fight? The patient, of course. Oh, it's a subtle fight. We're too "nice" to hit him in the nose—we talk about him—shun him and his family—put him in jail because he won't behave himself—deny his admission to the hospital because he brought it on himself.

I could go on with hundreds of examples like this, but you get the picture. It's not a pretty picture, is it? It doesn't make us much different from the animals in the woods, does it? What is our major difference from these animals? Isn't it our God-given ability to think and reason?

The ability to think and learn and reason is our greatest defense against the fear of the unknown. The time has long passed for us to try to ignore the problem. It is time for each of us to try to learn about it and to realize that alcoholism is a treatable illness which is seriously damaging thousands of people. We face other illnesses and do all we can to help people get treatment and get well. We talk to people honestly about their illnesses. We don't pretend they're not there. We are sorry he's got trouble; we don't get angry with him about it. Nor do we just sit back and say "too bad" and watch him half kill his family and maybe die himself. No, we gently, but firmly, insist that people get treatment for other illnesses.

We can learn enough about alcoholism not to be afraid of it; then the patients will not be afraid to try to do something about it! The attitude of people may well be the most powerful weapon against this dangerous enemy.

Dependency and Immaturity in Alcoholism

The ego, that part of personality structure which determines emotional balance, is in a state of growth or decline throughout life, and the course it takes may be said to depend upon life situations.

BY JAMES WOODALL
PSYCHIATRIC SOCIAL WORKER
BIRMINGHAM CLINIC
ALABAMA COMMISSION ON ALCOHOLISM

THE alcoholic has often been described as a dependent and immature person. The families of alcoholics are eloquent in their descriptions of over-dependency, childish temper tantrums, illogical resentments, irresponsibility, and other signs of immaturity. These families frequently describe the alcoholic as being a comparatively mature person prior to the onset of the illness. They cannot understand this change and they are further non-plused by the fact that these attitudes and behavior patterns have become progressively worse as the compulsive drinking continues. They are further perplexed by the fact, that with sustained sobriety, the average alcoholic returns to his former state of maturity, and often looks back in wonder and disgust at his over-dependency and childishness while in the throes of acute alcoholism. The question remains, what b r i n g s about this change in personality? Is this a change brought about by the illness or does the answer lie in the problem of causation of the illness?

One widely accepted theory is that the roots of the illness lie in childhood experiences which were so emotionally crippling that the alcoholic grew to adulthood ill prepared to meet the demands of an adult world. This implies that all alcoholics were emotionally immature people to begin with. However, the fact remains that there are many emotionally immature people who do not become alcoholics even though they drink, and it is also a fact that the ranks of alcoholism represent a cross section of our society. There is no such thing as the typical alcoholic personality, and the disease is not confined to any economic, social or intellectual level. Alcoholics are individuals, with a range of childhood environments, and also represent a wide range of accomplishments as adults.

There is good reason to believe that our personality patterns are established in early childhood, perhaps to a great extent before the dawn of our conscious memory. Certain childhood traits and attitudes prevail throughout our adult lives and are either minimized or magnified in proportion to the strength of our ego development, which determines the degree to which our personalities are molded into a well-integrated whole. However, the average student of human behavior tends to accept the theory of ego development in early childhood as a static condition which infers that the personality is set and unchanging. Actually, the ego—that part of the personality structure which determines

our emotional balance—is either in a state of growth or decline throughout our lives. It may be said that the growth or decline of the ego is dependent upon our life situations. To use a dramatic example, we are all familiar with the temporary (and sometimes permanent) emotional imbalance brought about by the death of a close relative, a divorce, or the shock of war. Less obvious is the decline brought about by a situation that slowly and insidiously causes a breakdown in ego functioning.

Whenever the ego is damaged, a state of regression occurs. Regression may be defined as an emotional return to some stage of childhood where the person concerned is seeking a state of dependency which will afford protection, care, and an overall feeling of security. It is actually an attempt to escape from reality. If a regression occurs and the dependency needs are not met, decompensation occurs and a further regression is brought about. Thus, a person moves further back into childhood and his thinking processes and behavior are increasingly more immature. It may be said that the degree of regression is in proportion to the traumatic experiences precipitating the regression and the strength of the ego at that time. In other words, a basically immature person would regress further than an emotionally mature person suffering the same experience. By the same token, a mature, well-integrated person may suffer a severe regression from some overwhelming experience. Under normal conditions the time required for the return to a well-integrated state depends largely upon the basic ego strength of the individual.

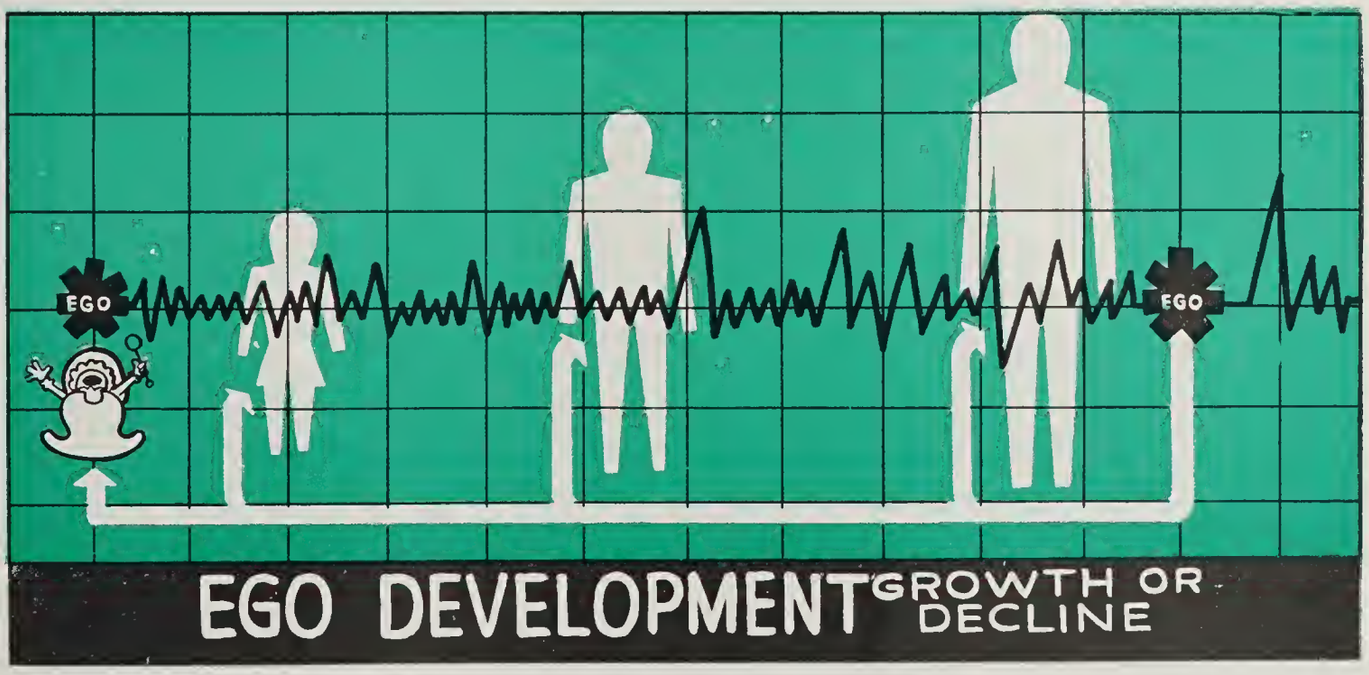
It is felt that withdrawal and regression, with its resulting dependency, are component parts of alcoholism. Alcoholism is marked by compulsive drinking as a means of temporary escape from reality. In clinical terms, this may be referred to as a social regression—a withdrawal from society—and the alcoholic is dependent upon alcohol to enable him to withdraw. It is a means of blocking out the anxieties of an environment that has become intolerable, largely due to the pressure of his own emotional conflicts. In others words, it is, for the most part, an attempt to escape, not only from the environment, but from one's self. It is not unusual for an alcoholic to change his geographical location, only to find that the "new start" does not eliminate the conflicts that he carries within himself, and the drinking continues.

The alcoholic may find temporary escape through drinking himself into oblivion, but his problems are increased when he returns to consciousness. The original anxieties that triggered off the drinking are still present, and in most cases have ben worsened as the result of the drinking. His behavior may have been such as to create additional problems. He experiences acute feelings of guilt, shame, remorse, inadequacy, and self depreciation. When these anxiety-producing factors are added to the extreme physical discomfort of the hang-over, there is a need for further escape through alcohol and a vicious cycle is set up which becomes progressively worse. Thus, the ego is under constant attack, the need to regress is more acute, and the dependency upon alcohol is increased. Obviously his dependency needs are not met, for alcohol has become a destructive agent rather than a crutch.

The elements of regression and dependency cannot be ignored in social drinking, and may even give some clues as to the causation of the disease itself. On the average, the ad-

diction occurs after some ten to fifteen years of drinking. The anesthetic effects of one or two high-balls afford some relief from minor irritations and fatigue and result in a feeling of well-being. This is a mild form of escape and may be considered a slight regression. Having experienced these effects, the social drinker may turn to alcohol in moments of stress. If this pattern is continued, he gradually becomes more dependent upon alcohol as a means of escape from the frustrations of everyday life and, with this continuance, the amount of alcohol needed to escape increases. The ego may be said to be in a state of decline because alcohol is used as a substitute for inner resources in meeting life's situations. The well-integrated person with no abnormal life situations may continue to employ alcohol as a crutch without its becoming a necessity. However, the less well-integrated person may continue to decline through the increased use of alcohol. He is progressively less able to tolerate frustrations and becomes more dependent upon alcohol. Certainly, both are subject to emotional imbalance from the stress of some environmental situation.

The above discussion involves some of the psychological factors in the illness, but it does not take into consideration the possibility of one or several bio-chemical changes that may occur after years of excessive drinking and that may well mark the difference between the heavy social drinker and the addictive drinker. We are still faced with the problem of what causes alcoholism. Until this is established, there is no "magic pill", and the sad fact remains that there is no cure which would enable an alcoholic to return to social drinking. It is true that the alcoholic, with help, can abstain, but once the first drink is taken he no longer has any choice in the matter, for the addiction makes him powerless over alcohol. Because of the emotional and moral issues involved, it is difficult for many people to accept the disease concept of alcohol. This explanation of regression and dependency in alcoholism may help as to clarification, but it can well infer that these factors are confined to alcoholism. This is far from the truth.



Frances Upham, in her authoritative book, "A Dynamic Approach to

Illness", points out that regression is a common and useful reaction in adults under stress, such as in illness. This is a defense reaction used as a means of handling anxiety that is too overwhelming to bear and should therefore be considered useful. She also points out that attempts to strip the individual of these protections by direct attack can result in greater anxiety and therefore more extensive defense reactions. Medical social workers in hospital settings have long been aware of the emotional components in illness and the necessity of fulfilling the dependency needs of the patients in a realistic manner. It is necessary for them to supply the support needed by the patient in order that he may recover his inner strengths and thereby cope with the realities of his situation. They are aware that the lack of this support, not to mention rejection, can bring about a further regression which in turn can impede recovery. By the same token, they are also aware that too much "coddling" can cause the sick person to seek secondary gains from his illness and use his illness as a means of manipulating those around him. This is often done by playing on their sympathies and getting his way through childish and tyrannical demands. Any one who has had the experience of taking care of a sick person in the family, particularly a physical illness that is confining and of long duration, is well aware of the childish petulance, irritability, and demanding attitudes manifested during the illness but disappearing upon the recovery of the patient. This childishness is irritating to those caring for him, but it is accepted because of the recognition that he is sick.

Like any other sick person, the alcoholic is petulant, irritable, demanding, self-centered, and unable to take frustration in stride. However, there is no germ or physically crippling condition present and these attitudes and behavior bring about an immediate emotional reaction from others closely involved. In so many cases the psychological factors that are present in all illnesses are greatly exaggerated in the alcoholic. When these are coupled with violent acting-out behavior, loss of employment, or incarceration, it is often too trying upon the emotional controls of even those who at least partially accept alcoholism as an illness, much less those who conceive of the compulsive drinking as a moral rather than as a medical problem. Too often this results in such ineffectual measures as nagging, lecturing, pouring the liquor down the sink and hiding the bottles. These practices only compound the situation, for they represent rejection, add to his deep sense of guilt and bring about an immature resentment which results in a continuation of drinking.

The result of a series of crises is that the structure of the family itself tends to be weakened and reorganization is often necessary for the sake of survival. The inevitable result is that the alcoholic is stripped of his former role of breadwinner, husband and father, and reduced to the status of a recalcitrant child. The family circle has closed and he is on the outside looking in. In such situations, the damaging psychological effects upon the alcoholic are easily understood.

It has long been recognized in the professional ranks that the key words in treatment of the alcoholic are acceptance and understanding, a basic human need shared by all of us. It is felt that this attitude of acceptance and understanding is one of the important ingredients in the success of Alcoholics Anonymous, for therein the alcoholic finds refuge from a society that has, for the most

part, rejected him. He must be accepted in the light of his worth and dignity as an individual. He must be helped to regain some semblance of his shattered self respect and once again to recognize his own assets. He must be given the choice to make his own decisions, but he must also be helped to recognize his adult responsibilities. It is of paramount importance that he recognize the seriousness of his problem and assume the responsibility of seeking help, not only for the sake of his family, but also for himself. Once in the treatment situation he must invest much of himself in what is often a slow, erratic, and sometimes painful process of regrowth through personality changes and modification of existing attitudes. The ultimate result is that he is not only comfortable in his sobriety, but comfortable with himself as a person.

The role of the family in the recovery picture is of prime importance. They must not only understand the facts of alcoholism per se, and learn intelligently to cope with the problem, but they must also emotionally accept the fact that the alcoholic is a sick person. With full emotional acceptance comes the compassionate attitude surrounding any other type of crippling illness. With a change in family attitudes, the emotional pressure is lightened and the alcoholic has a chance to take stock of his situation in a more objective manner. It can help him to seek treatment, and once this has started it can help him to stay sober. This is the preferred situation, but too often it is the exception, for many families (the wives in particular) refuse to seek professional counseling or the beneficial therapy of Alanon, the auxiliary of Alcoholics Anonymous. In such cases it is up to the alcoholic to recover in spite of his family. Here the struggle is truly heroic, but under any circumstances the battle is his. One thing must be fully understood. Help is needed and from various sources, but no one can force an alcoholic to stop drinking. It is his choice, his responsibility, his fight against the almost insatiable craving for alcohol, and the ultimate credit belongs to him.

The progressive over-dependency and the immature behavior of the alcoholic is presented as the result of a decline in ego functioning, manifested by withdrawal from reality and emotional regression to a childhood state. The elements of withdrawal and regression are also present in varying degrees in social drinking, which implies a gradual breakdown of ego functioning as the drinker becomes increasingly more dependent upon alcohol.

A state of regression occurs in all illnesses in varying degrees and is considered a necessary reaction used in handling anxiety. The regressive behavior manifested by all sick people is accentuated in the alcoholic and is often coupled with antisocial acting-out behavior. The emotional reaction upon those closely involved, the breakdown of the family structure, and the social and moral stigma around alcoholism often result in rejection rather than the support that is necessary. The traumatization of this rejection brings about a further regression. Emotional acceptance by the family that alcoholism is an illness, and their realistic support are valuable aids in helping the alcoholic to recognize his problem, to seek help, and to maintain sobriety. With sustained sobriety, coupled with changes in personality and modifications of existing attitudes, the alcoholic often returns to a state of comparative maturity.

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A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: Fifteen North Carolinians working in alcoholism or related fields will be recipients of NCARP scholarships to the Rutgers Summer School of Alcohol Studies to be held July 1-26, 1962 in New Brunswick, New Jersey. There has been an unusually heavy demand this year for these scholarships. This will be the first session of the school since it was transferred from Yale University in New Haven, Connecticut.

AVON PARK, FLORIDA: The Florida State Alcoholic Rehabilitation Program's **Reporter** has stated that the number of alcoholics in Florida has grown in the past ten years to a record high of between 140,000 and 150,000. The estimate is based on formulas obtained from national studies and a survey conducted in Florida by the late Dr. J. M. Machlachlan, former head of the University of Florida Department of Sociology.

REIDSVILLE, N. C.: The Rockingham County Committee on Alcoholism will be host to the semi-annual meeting of the Alcoholism Programs of North Carolina on April 27. Mrs. Anne Wall is executive secretary of the local council.

EPISCOPAL SURVEY: The **Episcopalian,** the national monthly magazine of the United States Protestant Episcopal Church, reports that alcoholism tops all the major problems brought to the attention of Episcopal clergymen by persons seeking help. The information was compiled from a questionnaire which was sent to 7,000 Episcopal clergymen.

GREENSBORO, N. C.: A group of outstanding leaders in the field of alcoholism will be on hand April 30-May 4 when the Greensboro Council on Alcoholism sponsors its annual Alcoholism Education Week. Appearing on the program will be Dr. Robert W. Russell, professor in the Department of Hygiene in the School of Education at Stanford University; Dr. George Maddox, visiting associate professor of medical sociology in the department of psychiatry at Duke University; John Park Lee, head of the department of public relations and interpretation of the Board of National Missions of the United Presbyterian Church of the U. S. A.; and Dr. Howard J. Clinebell, associate professor of pastoral counseling at the Southern California School of Theology in Claremont, California.

BUTNER, N. C.: Miss Roberta Lytle, psychiatric social worker at the N. C. Alcoholic Rehabilitation Center in Butner, will be a featured speaker at a conference in Rome, New York April 16, 17 and 18. The theme of the conference will be "Responsibility of Local Official Agencies." Miss Lytle will speak on "Alcoholism and Families in Crisis." The conference is sponsored by the Division of Alcoholism of the New York Department of Mental Hygiene, the Interdepartmental Health and Hospital Council and the National Institute of Mental Health.

SHREVEPORT, LOUISIANA: Centenary College in Shreveport, Louisiana will sponsor its sixth annual Institute on the Problem Drinker on May 9 and 10. Mrs. Marty Mann, Executive Director of the National Council on Alcoholism, and Dr. Tom Shipp, minister from Dallas, Texas, will participate on the program.

CHAPEL HILL, N. C.: The Orange County Council on Alcoholism has distributed more than 700 copies of the booklet, "Facts About Alcohol," by Dr. Raymond G. McCarthy to students in Orange County schools who will be receiving instruction about alcohol during the school year. The distribution of these booklets is only one phase of the council's educational program. The group also distributes other educational materials and loans films to individuals and community groups.

BUTNER, N. C.: Donald E. Macdonald, M.D., medical director of the North Carolina Alcoholic Rehabilitation Center, has announced a change in admission requirements. Telephone or letter requests for admission will be received as before but all appointments will be confirmed from the Center by mail. The letter of confirmation to the patient will include the admission requirements, a brochure about the Center, house rules which the patient should read and agree to follow, and the date and time to come to the Admitting Office. This change will be effective April 1, 1962.

NEW HAVEN, CONNECTICUT: Dr. Leon Greenberg of the former Yale Center of Alcohol Studies recently stated that he has found no evidence that alcohol has a greater effect on persons between 18 and 21 years of age than on older persons. In fact, he said that the younger age group was affected less physiologically and biochemically than their elders.

MENTAL HEALTH SURVEY: Findings of an intensive five-year study of the country's mental health status by the Joint Commission on Mental Illness and Health have been recently made known. Money and other economic considerations (or lack of them) are one of the major sources of happiness and unhappiness, and for most people, their families are the greatest source of happiness. Fewer than one person in ten expressed great concern for community, national or world problems (as sources of worry). This indifference may be due partly to the fact that the extent to which worry and tension affect us decreases in proportion to their remoteness. It may also reflect a feeling of helplessness about things that individuals cannot control. Most people revealed that they are actually very happy, with only one person in four admitting that he worries quite a bit.

1962

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EDITORIAL

UNDERSTANDING SCIENTIFIC RESEARCH

THE two research articles in this issue of *Inventory* are offered in the hopes that they may provide the non-scientific reader with insights into scientific research in general that may not have occurred to him before. Discerning readers will, of course, also learn from them a good deal about the ramifications of alcohol, alcoholism and its concomitant problems, certainly indirectly, if not directly.

Why be concerned with the non-scientific person's understanding of some of the problems in, and limitations of, scientific research? Research is a popular subject—one of such widespread interest, in fact, that almost everybody is for it and there are few, indeed, who would dispute its value. Is it not enough, then, that the average lay person in this scientific-minded era is cognizant of the importance and place of research in the general scheme of things?

On the surface, perhaps, this would seem to be enough to expect from the average lay person. The popularization of scientific research without an understanding of its nature, however, is fraught with dangers in a field so complicated as alcohol and alcoholism. While the popularization of research, at first glance, may *seem* to serve the purpose of stimulating interest, popularization without understanding is likely to hurt research efforts in the long run, particularly those which must look to the public for support. Why?

The sometimes dramatic results of scientific research, particularly in the non-scientific mind, have a way of overshadowing the fact that the carrying out of scientific research is hard, painstaking work by hardworking men and women who, though they usually are of superior intelligence, are not "miracle workers" but highly skilled people who have spent years preparing themselves for their careers.

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RESEARCH-Its Meaning and —SOCIOLOGICAL

Programs of agencies in the field of alcoholism to be effective must be maintained at a level which current knowledge stemming from sociological research makes possible.

BY R. WALLACE JONES, M.A.
DIRECTOR OF RESEARCH
ALCOHOLISM FOUNDATION OF ALBERTA

This article was originally given as a talk at the 1960 annual meeting of the North American Association of Alcoholism Programs held in Banff, Alberta, Canada, and was one of the papers selected for publication in the NAAAP "Selected Papers of 1960." Published in Inventory by permission of the author, its original title was "Implications for Administrators of Recent Sociological Research."

THIS paper is an effort by one social scientist to indicate what **he** believes to be the important consequences of recent developments in knowledge, stemming from the work of other social scientists—particularly sociologists and anthropologists—for the short run and long run programs of operating agencies in the field of alcoholism.

It would be presumptuous for a social scientist to tell the administrator how to run his program. Yet having a social scientist discuss his views of what new research means for operating programs can have some real practical values in integrating present understandings about alcoholism and the use and abuse of alcohol with more recent findings.

The administrator must have a concise, reliable review of sociological research if he is to maintain his program effectively at a level which current knowledge in the field makes possible. One of the strong implications, then, is that the administrator must somehow make available to himself a line of communication from the research scientists which will ensure that he is, at all times, fully abreast of recent developments.

Research scientists themselves generally do not make the job of communication easy. They are not accustomed to examining their findings for operating purposes. There is in North America a great reverence for basic research—a reverence which is fully justified, but one which has resulted, in many cases, in the research scientist cutting himself off from the practical implications of his work.

This is unfortunate. It means that the scientist is, in effect, ignoring one of his major responsibilities, a responsibility for the use to which his material is put. This is not to suggest that the scientist should interpret his material for every situation in which it might be used. He does have, however, a moral responsibility to provide the general frame-

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pplication to Alcoholism Programs

—PHYSIOLOGICAL

BY HAROLD KALANT, M.D., Ph.D.
ASSOCIATE DIRECTOR OF RESEARCH
ALCOHOLISM FOUNDATION OF ONTARIO

The development of a truly rational approach to the treatment of alcoholism requires the acquisition of knowledge in answer to three basic questions of physiological research.

This article is based on excerpts from the paper, "Some Recent Physiological and Biochemical Investigations on Alcohol and Alcoholism," published by the Quarterly Journal of Studies on Alcohol, March, 1962 and used by permission. The section subtitled "Choosing Research Projects" did not appear in the Journal but was in the original paper presented at the 1960 NAAAP meeting.

THE aim of physiological and biochemical investigations on alcohol and alcoholism is to find a truly rational approach to the therapy of alcoholism. It seems fairly self-evident that the development of a rational program of treatment or prophylaxis of alcoholism requires the acquisition of knowledge in answer to three basic questions.

The first question is: what is the basic action of alcohol upon the body at all levels of function and integration?

Most attention in this area in the past has been directed to the action of alcohol upon those systems which are most obviously affected by immediate and by chronic intoxication, specifically the central nervous system and the liver.

With the expansion of knowledge on the functional interrelations, it has become clear that the metabolism of the liver affects the function of the central nervous system; that psychological and peripheral sensory stimuli acting on the central nervous system affect the release of various factors; that these various hormonal imbalances affect the metabolic behavior of the liver and of all other tissues including the brain—and so on and on. Because of this, it becomes very difficult, indeed, to pick out those effects of alcohol which are primary, and those which are secondary and non-specific consequences of the disturbance resulting from alcohol.

It is therefore necessary to acquire knowledge concerning the fundamental nature of the action of alcohol upon individual tissue cells, whether in the brain, or the liver, or elsewhere. Through such knowledge, it may be possible in the future to sort out the chain of events in the whole organism by knowing which effects of alcohol are indeed primary and which are secondary.

The second basic question to be answered is: why do some individuals who drink become "alcoholics" while others do not?

It is common knowledge that

every human being who ingests alcohol will become intoxicated if he drinks enough of it. It is equally common knowledge that the great majority of those who at one time or another have become intoxicated do not become alcoholics. One must presume, therefore, that those who do become alcoholics are in some way more susceptible than the others to the effects of alcohol, or else to some qualitatively or quantitatively different effects of repetitive exposure to too much alcohol.

This greater susceptibility must not necessarily be interpreted as a greater physiological susceptibility in the form of a lower threshold for intoxicating effects. It may be a psychological susceptibility in the sense that, as a result of psychological or social pressures, the same physiological effect of alcohol may prove more gratifying to the potential alcoholic than to his fellow drinker.

This hypothesis, of course, underlies a very large part of the psychological and sociological investigations into the causes and treatment of alcoholism. To the extent, however, that psychological pressures have physiological consequences and, also, that psychological function in the last analysis must depend upon the metabolic functions of the individual brain cells, it is also justifiable to look for potential physiological differences between individuals that may predispose one person more than another to alcoholism. In this respect, it is also essential to investigate the recurrent "craving" for alcohol which is experienced by alcoholics in order to know whether it results from physiological effects of alcohol or from the psychological makeup of the alcoholic.

If we know how alcohol acts upon the various cells and organs of the body, and if we know how one person differs from another with respect to susceptibility or proneness to these effects, the third basic question to be answered, in order to permit rational therapy, is: what pharmacological agents or procedures will prevent, counteract, or diminish the action of alcohol upon the susceptible individual.

This is the logical basis for drug therapy which therapists desire. Unfortunately, if we were to wait until a rational basis were discovered for every treatment used in medicine, we would wait for a good many lifetimes yet and treat very few patients indeed.

Most therapy is still empirical. Therefore, a necessary and perfectly legitimate field of physiological investigation in alcoholism is the experimental and clinical trial of any form of therapy which associated knowledge, intuition, or divine or diabolic revelation indicates is likely to be of some help and at least of no harm. By its very nature, such empirical observation is likely to be a wasteful procedure because most ideas which occur without any sound rational basis are likely to prove wrong. Yet, despite its low percentage yield, this method of investigation is still necessary for the reasons already given.

Choosing Research Projects

Having outlined what I consider to be the three basic questions in the investigation of physiological aspects of alcoholism, I should like to offer a few remarks in connection with the choice of research problems for support by alcoholism agencies.

All the possible problems of physiological and biochemical research can be classified according to the three main questions outlined but, for obvious reasons, it is impossible to give preference to any one of these three main questions over the others. They are all essential to the

ultimate discovery of rational therapy. Therefore, in judging the usefulness or validity of any single research question, I think there are three principal criteria to be used.

First, does the proposed investigation ask a reasonable question? I think that any research question is a reasonable one provided it is based upon adequate pre-existing knowledge and goes only one step at a time in advancing from that previous knowledge. For example, I think a reasonable question in advancing the finding that glutamine reverses alcohol toxicity in bacterial growth would be to ask *how* does glutamine reverse alcohol toxicity in bacteria, *not* is it likely to cure chronic alcoholism in humans? A less ambitious question, going one step at a time, is much more likely to yield useful answers.

Second, does the proposed research use reasonable methods to answer the reasonable question? The adequacy of techniques and apparatus, in relation to the problem undertaken, has often been a limiting feature in the past. The development of chromatography, for example, or the introduction of radioactive isotopes, have made it possible to carry out many investigations which simply could not be done with previously existing methods. A thorough knowledge of techniques by the person judging the prospective research project is therefore necessary in order to know whether these methods are likely to yield answers of sufficient accuracy or relevance.

Third, do the people who propose to do the research have a broad background, not necessarily in the field of alcohol studies, in the branches of science relevant to their proposed investigation? This becomes particularly important in those fields of investigation which cross the lines of traditional disciplines. For example, the investigation of the endocrine or metabolic effects of psychological stresses, and the modification of these effects by alcohol, could be conceivably carried out either by an experimental psychologist or by a physiologist. It would be rather unlikely that one would find a person equally well-qualified in both fields. Yet the use of methods with which one is not sufficiently familiar can give rise to gross misinterpretation or failure to recognize sources of error within the methods themselves.

Interdisciplinary Approach

The most widely used answer to this difficulty is the so-called interdisciplinary approach in which teams of workers drawn from different fields of research pool their experience and abilities. It is, however, perhaps too easy for each member of such a team to confine his attention exclusively to portions of the project derived from other disciplines than his own. Unless the members of such a team acquire sufficient knowledge of each other's fields to provide reasonable criticism as well as mere technical collaboration, the project will be no better than the contribution of its weakest participant.

Most of the research reports of the last two or three years which, in my opinion, are most relevant to the basic questions in alcohol and alcoholism research have succeeded in raising questions rather than answering them. This view of available knowledge indicates that there can be no rational therapy for the treatment of alcoholism at present. It is concluded, however, that there is need for much research in relation to all three of the questions asked, and that the best approach to much of the research is the interdisciplinary one.

CONTINUED FROM PAGE 16

work in which he feels his material has meaning. He, of course, does not have to provide such a framework for fellow scientists who, presumably, are able to interpret the qualifications of method and of theory around his particular piece of research. But too often he neglects to communicate effectively with those who need to use his data most directly.

A good deal of what is called practical or applied research requires an equal, if not a greater, amount of interpretation than does basic research. In basic research, we are reasonably certain as to the kinds of bias which are built into the study by the predilections of the investigator. The man doing basic research has a particular set of biases, or opinions if you prefer, which stem primarily from theoretical positions and the axes which he grinds are usually explicit. However, the biases and opinions of the worker doing applied research may very well stem from his need to sustain a particular public appearance, say before a government or a board of directors. Consequently, the kinds of biases inherent in his work are not quite so obvious to the person examining such research for its operational purposes.

It takes a very long period of training and a high degree of awareness of the implications of particular methodologies and theoretical frameworks before a person is truly capable of judging the meaning of a particular piece of research. There may well be many administrators in this field who are quite capable of doing just that; but certainly there are few who have the time required to examine in detail each of the many new studies now becoming available. How, then, can this be done? There appear to be two practical and simple ways of solving the problem.

The best way is to have a person on the staff who carries out this function, who is available to clarify details and to give special attention to research which seems to be of major importance for the locality and program at hand. The availability of a full time social scientist is useful for not only conducting and evaluating research but for evaluating and examining educational and treatment programs, as well as, and perhaps more importantly, preventive concepts. It is also quite possible to have a consultant who would perform these functions on a part-time basis. Every program in North America has available in the community in which it operates people who are capable of carrying out such duties and who would be very pleased to do so for a reasonable fee.

Another way to provide a good line of communication is for some publication to be established which would devote at least a part of its pages to this kind of activity. Though there is none at present, a publication devoted to the interpretation of sociological research, as well as pharmacological, physiological, medical and psychological research, would serve a very useful function to administrators.

Turning now from the implications of the sheer mass of the new research in alcoholism, we will consider some of the broad directions this research is taking and what they may mean for the administrator in the short run and long run programs of operating agencies in the field of alcoholism. One or two projects which are current or recently completed will be mentioned.

In recent times sociological research has tended towards a description of patterns of behavior

rather than towards collection of demographic data. This is a general impression to which numerous contrary examples may be cited.

One exception is particularly worthy of note. *Statistics of Alcohol Use and Alcoholism in Canada* by Popham and Schmidt is a tremendously important contribution to our knowledge about alcoholism. The care and effort which went into the preparation of their material has produced an extremely important piece of source material. One can criticize a number of items in the compilation, yet the results of that work have been of considerable use to almost every research person in the field. It is incumbent upon anyone using this work to be fully cognizant of the limitations in the application of the material, but we now do have statistical information on some of the demographic characteristics of alcoholism and of populations in which alcoholism occurs.

Current Trends

The work that is typical of current trends in sociological and anthropological studies in alcoholism is exemplified by such work as *Alcohol and the Jews: A Cultural Study of Drinking and Sobriety* by C. R. Snyder; *Revolving Door: A Study of the Chronic Police Case Inebriate* by D. J. Pittman and C. W. Gordon; and *Alcohol in Italian Culture: Food and Wine in Relation to Sobriety Among Italians and Italian-Americans* by G. Lolli, E. Serianni, G. M. Golder and P. Luzzato-Fegiz. The emphasis in these studies has been to describe the cultural patterning of alcohol use and of alcoholism. These are only three examples and there are numerous others which could be cited. Somewhat different, but a part of the same broad trend, is *Drinking in Iowa I-V,* a study conducted by H. A. Mulford and Donald E. Miller.

What does it mean that we have this growing trend toward a cultural approach? The important implication is that we are moving very rapidly towards attaining sufficient information to embark upon true preventive programs. We have accumulated the broad, basic data and it is possible now to find meaningful patterns in them. In the public health sense we are beginning to get enough information to develop an epidemiology of alcoholism.

Now the long run implication of an epidemiology of alcoholism is that we will no longer be permitted, not by others but by ourselves, to use our resources in broad, scattered, shotgun approaches to treatment, education and prevention. Rather, we will rapidly be forced into the development of programs designed for specific segments of the population, to take into account many of the factors which we are growing to recognize as related to alcoholism and to the development of alcoholism.

Perhaps an example would be helpful here. Lolli *et al* report that the incidence of alcoholism among persons of Italian descent living in North America tends to increase the greater the number of generations residing in North America. This is attributed to an acculturation process in which the ensuing generations become more and more like the North Americans whose ancestors have resided here for a large number of generations.

Now, if this were an isolated finding, it would have important implications for the research worker but would be little more than an interesting bit of information for administrators. It is not, however, an isolated finding since a number of studies have indicated a tendency for people of particular cultures to shift their drinking patterns to that of the

majority in North America. In some cases this has meant an increase in apparent consumption and in others a decrease. In some there has been an increase in alcoholism and in others a decrease. Unfortunately, the apparent amounts consumed and rates of alcoholism do not always change in a direct relation. Sometimes one goes up as the other goes down. However, this seeming contradiction need not concern us here.

All of this suggests that we might need different kinds of approaches to different kinds of people. And by this is meant something other than: each individual must be treated as an individual. We must take into account the values and beliefs which people share as a part of their common cultural background, whatever that culture may be.

Educators and Clinicians

If we have any success at all in developing an epidemiology of alcoholism, then it will be incumbent, particularly upon educators, as well as clinicians, to evaluate their programs in terms of effects on specific groups.

This is in no sense a very startling statement. We should have been doing this since the inception of our programs, but it is highly doubtful that any beginning program is inherently capable of doing much more than approaching the total population. Certainly it is only in the last five years or so that there has been sufficient information to indicate that alcoholism may have differential rates among different groups of people in our societies. Whether the findings of these studies have immediate application is, of course, debatable. There can be no question if similar studies produce similar results that the programs of the operating agencies must be examined to determine whether or not they are capable of handling the various sub-cultures which are present in modern North America.

Another set of sociocultural factors in alcoholism which are only beginning to be examined are the institutional relations to alcoholism. It is perhaps inappropriate to mention these studies before we have some final papers on the results. However, the tendency towards this kind of work has increased so much in the past two years that, despite a lack of results from the investigations, we know that they will have strong implications for the operating programs. We have the example of Robert Popham's study of the tavern carried out in Ontario which is in the process of write-up. Another study of this kind is of the legal institutions and their relationship to alcoholism. Again, we have no results, yet we know from these investigations that we are going to derive a somewhat different picture of the social factors which influence the development of drinking patterns and attitudes.

Some of the economic relations to drinking behavior are coming under intensive study. There is a preliminary report in *ALKOHOLPOLITIK,* No. 2, 1960, which discusses the effects of an intensive educational program coupled with price adjustments on the consumption of light wines and spirits. In the year that the program has been in operation in Finland there has been a perceptible increase in consumption of light wines and a decrease in consumption of spirits. This suggests that there may be measures which can be taken to change consumption patterns. We must test this kind of activity in North America before we can apply such measures. However, we do have some evidence now that institutional influences can be used to change consumption patterns.

One area of study which has not been undertaken is the church. This is one of the most important institutions in our society which has an effect upon people's drinking patterns and people's attitudes towards drinking. Thus far we have had only informed guesses as to what is happening in relation to the churches. There is no doubt, however, that it will be critically important in the not too distant future to determine with some degree of exactitude how the church affects drinking, in what ways the church intends to affect drinking and how the church's "ideal" patterns of behavior relate to real patterns of behavior. Perhaps equally important is the kind of influence the church brings to bear not directly on individuals as such but on other social institutions.

Important Considerations

Work in the institutional area has just begun. When we have developed good research reports on four or five of the institutional relations to alcohol and alcoholism, we can expect to be able to make some pretty definite statements about what the important considerations are in prevention of alcoholism.

You may feel that this is speculating well beyond current knowledge. True. But if we are to be aware of the implications of research, then we must be aware of what is going on as well as what has been published. Unfortunately, publication runs well behind actual research activity. Meanwhile, the research in progress is bound to influence both the general public and the programming in the communities where it is conducted; and the response of administrators who understand and are concerned can in large measure affect the quality and the direction of new research which will be forthcoming in the future.

Understanding Scientific Research

CONTINUED FROM PAGE 15

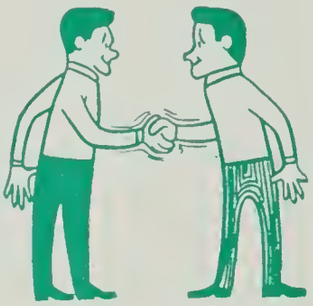
The glamorization of scientific research, without a corresponding understanding of its nature, may lead people to expect too much from scientific research too fast or, on the other hand, to confuse it with such things as fact finding, observation, statistics, discovery or just plain accidents. All of the latter factors may be involved in a piece of scientific research, but certainly they are not scientific by themselves unless they are a part of an organized effort set up along the lines of a controlled, scientific study.

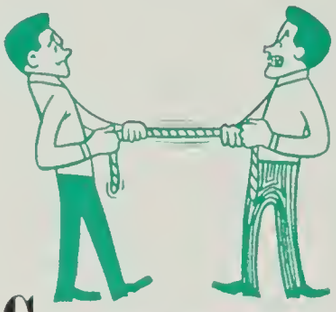
Such possible misconceptions are incompatible with the nature of scientific research. Scientific research must of necessity be continuous and sustained over a long period of time to produce results. It must be conducted by competent personnel. Needed support for quality research will, therefore, come from a patient, understanding public, not one which is expecting too much too fast or one which does not know enough about scientific research to recognize and demand excellence from the programs it supports.

Education about research in general would, then, seem to be a proper sphere for *Inventory* since progress in the field of alcoholism most surely will depend upon the quality and fruits of *scientific* research in whatever area of relevancy—physiological, sociological, psychological.

The research articles presented do an excellent job of explaining in an easy to understand way some of the problems in, and limitations of, scientific research. They further forcefully point up the simple, but sometimes overlooked, postulate that effective research efforts are purposeful and their fruits are applicable to operating programs. (L.W.)

Strengths and Barriers of Communication within the COMMUNITY STRUCTURE





BY NORBERT L. KELLY, Ph.D.

ASSOCIATE DIRECTOR
NORTH CAROLINA
ALCOHOLIC REHABILITATION PROGRAM

A sociologist discusses strengths and weaknesses of the educator and communication media which help or hinder the educational process.

THERE are strengths and barriers within the community structure that facilitate or inhibit the educational process. A discussion of the strengths and barriers that help or hinder alcoholism education within the community may be based around the four familiar communicational elements: The *communicator, media, audience* and *content*. Any or all of these may advance or retard our educational effort.

Let's begin with the most important of the four elements—the *communicator*. I believe the educator, whether he be one, or several, or many in the community, is the most important of the four because he controls the selection and operation of the other three. What, then, may be his strengths and weaknesses? How may he function as a strength or barrier?

If he knows his community, especially its group structure and its power structure; if he is a stable individual, highly motivated but with no personal crusade to wage; if he is skilled and experienced in communicational process; then he may function to facilitate the educational program.

Conversely, if the educator does not know the decision-makers and purse-holders in his community, he may be in for trouble.

I have seen the trained but inexperienced health educator come into a community and plunge into educational activity without first getting a "feel" of its social structure. And I have seen programs directed by these same educators fade and dissolve because conflict developed with the "unknown powers."

I have seen vested interests take over community programs and run them for their own benefit. These vested interests may be financial in

This article consists of the first portion of a speech given by Dr. Kelly at a regional conference on "Developing a State-Wide Alcohol Education Program" held in Birmingham, Alabama January 30-February 1. The latter half will be published in the May-June issue of Inventory.

nature, or the reward that control reaps may be emotional—the satisfaction of needs for power, prestige, recognition.

There have been people operating educational programs whose only qualification is their "interest in the problem."

A friend was telling me the other day of a recent visitor to his office. The visitor was a super-charged individual, imperious and commanding. He demanded a job in alcoholism education. He was used to making $30,000 a year and "managing" organizations. He threatened to go right to the governor if that job wasn't produced at once. According to this man, he had the only qualification needed for community education—"he had definitely solved his problem." I'm told the visitor was "eased" elsewhere—to satisfy his ego needs.

Then there was the man who disrupted a beginning community alcoholism educational program because the inexperienced and abrupt director did not adequately involve him in the program's activities. The director didn't know the behind-the-scenes decision-makers for his program. The angry man did. No happy ending resulted.

Merely knowing the power structure as it is related to your program is not enough. Those who control the purse-strings must be sympathetic to your objectives. If they aren't, needed program development may be thwarted.

Local funds were reduced in one community program when a grant from an outside source was obtained. The outside funds then merely brought the total budget up to its original level. The needed development was successfully inhibited because the community powers didn't understand the necessity for expansion. When community funds are used to finance an educational program, those who control the funds must be educated. If not, a real barrier to functional adequacy is posed.

Sometimes the flow of alcoholism education may be impeded by the anxiety or the jealousy of the educator. He may not want other community agencies poaching in his territory. Perhaps he is afraid that his function may be usurped. Or he, as a member of his group, may have had an unpleasant experience in agency cooperation in the past, and this has become a generalized attitude toward all potential cooperation.

For example, we know of untrained educators who make no effort to cooperate with the other health agencies in the community which are also concerned with problems of alcoholism.

These alcoholism educators are making a big mistake. No single agency bears all the responsibility for combatting alcoholism. No single agency can. The problem is far too large and widespread. Those of us working in this particularized field need all the aid and understanding from allied agencies that we can get.

My own experience working with other groups has been 99.44 per cent positive. In fact, I consider allied cooperation not only mandatory in combatting alcoholism, but I've found it to be one of the great community strengths. On the state level we've had excellent working relations with mental health clinics, mental health societies, departments of health, departments of welfare, P.T.A., parole supervisors, college faculties, etc. We have programmed cooperatively with all of these and others. We have worked with them on their particular areas of interest and they, individually, have included alcoholism in their efforts.

Collaborative effort will take us

much further in the fight against alcoholism than the specialized agency can achieve alone. Indeed, we are shortsightedly shortcircuiting our own endeavor unless we elicit the cooperation and help of others.

The uneducated educator may acquire education, the uncooperative educator may learn to cooperate, but there are other essential qualifications the successful communicator must meet.

Ideally, he should be vigorous and healthy, able to move about the community easily. Ideally, too, there shouldn't be home conditions that interrupt the job he is attempting and prove an obstacle to his functioning. Just being well-liked in a community is not a sufficient qualification for this work, either.

I have heard of educational programs wherein all of these characteristics have been ignored in the selection of the executive secretary.

The personalities of those working in alcoholism education can either facilitate or inhibit their work. I've hinted at this before. Now I'd like to underscore its importance.

I've seen cases where a curt, business-like personality has alienated communities and people in power. And I've seen cases when tact, and subtlety, and the desire to be of service have melted barriers and furthered the goals of an educational program.

The able educator has to know something about human emotions and needs. He has to know how to get along with people. He's fighting an illness, not a community. He's trying to help people, not order them or direct them. He's not running a business operation or trying to win an efficiency award. He can't afford to carry a blunderbuss. Yet some do.

Without realizing it, some are trying to militate alcoholism out of the community, not educate toward its reduction. In these cases, the educators themselves become strong barriers to the achievement of a humanitarian goal.

So far, I've emphasized what I believe to be certain strengths and barriers to community education found in the educator himself. I've spoken briefly about his personality, his knowledge of community social structure, his training and experience, his age and ability to get about the community freely.

I've mentioned the importance of educating the purse-holder and the vital significance of cooperating with other agencies, and keeping free of vested interests.

Though I have by no means exhausted the list of strengths and barriers in regard to the educator, let's leave him now and go on to the second element in communication—the media used.

Media of Communication

Any program would be severely handicapped if it did not involve all possible media of communication. This applies at both state and local levels. Moreover, where media personnel can be involved directly in the local community effort they can be an invaluable asset.

The community council that includes among its members representatives from the press, radio, and television has automatic access to these important channels of communication. In lieu of this, it pays to cultivate close, personal relationships with the media managers.

I know, of course, that it is popular to assign the mass media a secondary role in alcoholism education. I know, also, that academic students of the communication process are in relative agreement that the principal audience effect of the

mass media is reinforcement, not attitudinal change. But who posits attitudinal change as the only goal of our efforts?

In almost any community there exists a felt-need for knowledge about alcoholism. In fact, this is one of the great strengths we should be aware of. Large numbers of people want to know about the illness. Many want to know what can be done about it. How can my husband, or wife, or brother, or son, or my neighbor next door be helped?

Thousands of people want help with this problem. Don't ever think you're going to reach them all through face-to-face education. You're not. Some, unfortunately, so isolate themselves from all media that they are unreachable by any. Some can and are being reached through the mass media—with relatively little expenditure of educational effort.

For example, every two months a set of six radio spots is prepared in our office and distributed throughout the state. Some go directly to the radio stations; others go to the local alcoholism programs to be delivered personally to the stations. The total effort involves very little time. Yet seldom a week goes by that we don't receive approximately a half-dozen requests for help.

There's an interesting pattern to the responses we receive. On the whole, they are desperate pleas from relatives seeking help for an alcoholic member of the family. They come frequently from small, relatively isolated communities where there is nothing in the way of organized alcoholism education or treatment.

Such communities are unlikely to be included in face-to-face programs because of their small size and isolation—given the lack of staff of state programs. For many in these communities their principal contacts with the large world are the mass media. They can be reached through the weekly newspaper, the radio, and increasingly, television. I believe the mass media can be a strength in the scattered community.

Probably all media can be used effectively with some people at some time. Even attitudes, it is being found, sometimes change after exposure to mass media.

Limitations of Media

I believe it is helpful to be aware of the limitations of all media and not expect more than a given one can produce. In this context, I am aware of the power that is frequently attributed to groups in attitudinal and behavior change. In comparison with the group, various other methods such as lecturing, talking to community audiences, etc. are held to be ineffective. I'm fairly sure this is true—on the whole. Yet the rewards from the use of the other media are such that they should be employed. Let me cite several examples.

As the result of one twenty minute talk to a civic audience, a druggist had his license to practice restored and his family's style-of-life increased from lower to comfortable middle class.

From the same brief talk a member of the audience interested a relative in joining A.A. This was eight years ago. The relative has been sober ever since.

You wouldn't expect a two-weeks college course which, because of size, is largely lecture to be very effective. Yet pre and post course testing leads me to believe that there is substantial attitude change taking place as the two weeks progress.

I'm sophisticated enough in learning theory, however, to know that some of this modification may be

temporary. But I know also that some of it isn't. Not infrequently I hear from some of the students—graduate teachers—years later. They tell me how the course opened their eyes and changed their behavior.

The side-effects of the course, too, are usually interesting and important. In a class of 115, I can depend upon at least ten of the students attending because of a problem in the family or among friends. I have personal conferences with these students and try to be of help.

My point is this: If there is a college in the community, it may well serve as a valuable medium not only of alcoholism education, but of service, also. And the muchly vilified lecture method may be the first step in a two-step process of education. Many of these students have told me that they would have been too ashamed to approach me for personal consultation had they not had the chance to get to know me from behind the lectern. Their embarrassment over having a problem in the family would have effectively shackled communication. Of course, I believe it's obvious that the second step in this two-step process involved small group interaction between the student and the teacher.

Groups *are* important in education. The more we can work with them on an intimate, interactive, interchange basis, the more effective will our programs be. Feedback facilitates communication and especially persuasive communication.

Agency activity is not necessarily education—even when it is hyperactivity. In fact, it's possible for a program to keep itself so busy that its very activity becomes a barrier to reaching its goals. No time is set aside for evaluation.

We really don't know the relative value of the various media. Very frequently we are unable to evaluate the results of a specific educational project. We just don't have the time, or the skills. Every year thousands of pieces of literature are distributed. Innumerable talks, and radio and television appearances are presented to the public. Inservice training, workshops, conferences of all kinds are carried out. There is constant, almost unrelenting alcoholism communication at work. But what does it all result in? We really don't know.

I sincerely believe it is time that we begin seriously to think about building evaluation into our educational programs even though this may mean some diminution of the number of projects. Only when we know what we are accomplishing, or not achieving, can we reformulate our methods and techniques.

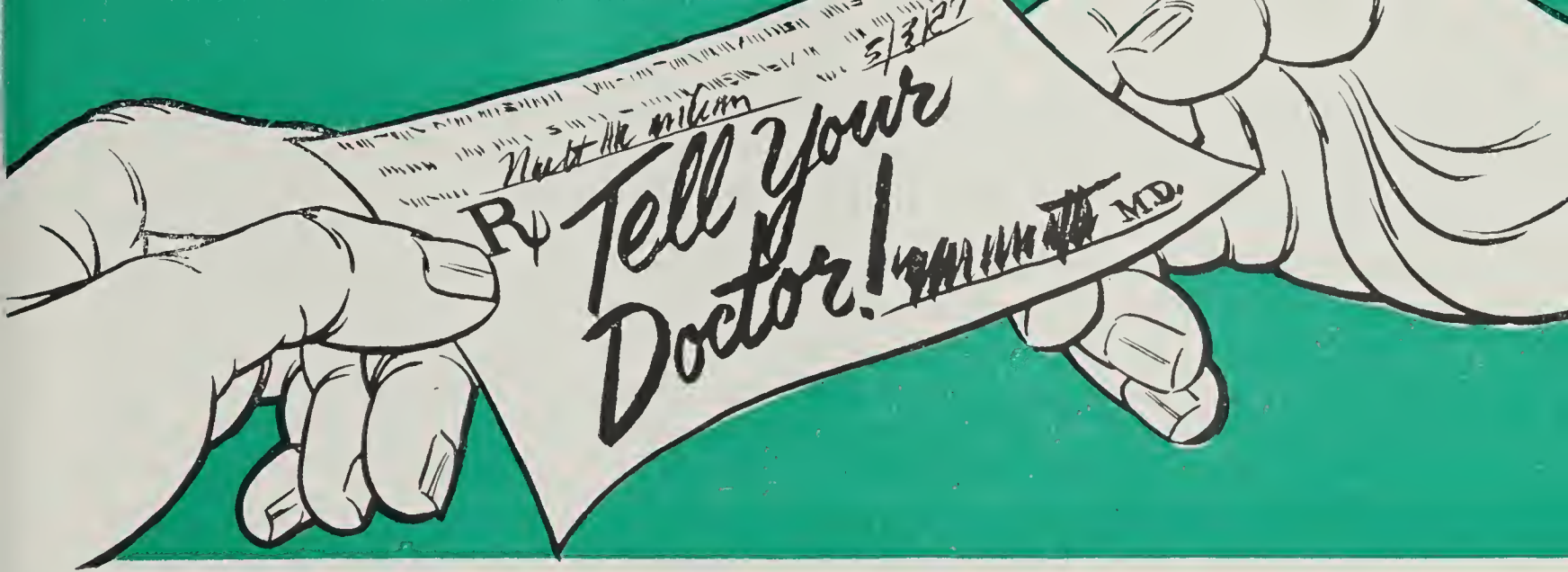
Up to this point I've emphasized the need for program planning as it is related to program evaluation. I have implied that the state of communicational knowledge today is one of uncertainty concerning the value of the several media. While it is apparent that all media may be effective under certain conditions and under certain expectations, we need a rational evaluation of these effects.

It was stated also that the mass media may play a special role in reaching the scattered community and the small community.

In most communities, media personnel can be influential members of the educational program. In absence of their direct activity, close relationships with them should be developed.

And, finally, I mentioned that there are individuals and groups in the community that seemingly no media of communication can reach. This is a point I wish to elaborate upon in discussing the third element of communication—the audience.

(To be continued next issue)



An AA member can protect his sobriety by confiding in his doctor.

BY DR. H. S.
LOS ANGELES, CALIFORNIA

I am an alcoholic. As a direct result of my alcoholism I became a drug addict. Because of these two addictions I lost my family, my home and the right to practice my profession as a doctor of medicine and surgery.

Through Alcoholics Anonymous I now have a loving wife and two adopted children, and I am once again serving my fellow man as a licensed physician and surgeon.

For more than five years it has not been necessary for me to take alcohol in any form, nor to use any habit-forming or narcotic drug. Once I considered myself a doctor who happened to be an alcoholic. Today, I regard myself as an alcoholic who just happens to be a doctor. But this is not the story of a doctor's fight against booze or of his personal recovery through AA. It is, instead, the reflections and honest convictions of a member of AA who has observed the disease of alcoholism from both ends of the stethoscope.

One of the great dividends of being a member of AA is that we are privileged to see some wonderful things take place in our own and other lives that reinforce our sobriety.

Let's take the experience of my friend, "Dr. Jones", and his patient, Bill. Bill had a heart condition. He was also an alcoholic. My friend, a very devoted doctor, worked patiently with Bill over his two problems and, as so often happens, was unsuccessful in treating the alcoholism. But Bill found his way to AA, sobered up and stayed sober.

Dr. Jones was so impressed that when Bill came to his office for frequent check-ups, he would ask him about this AA thing. And Bill tried to explain to him how a "Power greater than himself" had restored him to sanity. The doctor, however, failed to be convinced.

One night, Bill had another heart attack. Dr. Jones was summoned, and rushed Bill off to the hospital. Later that night, when it seemed that the immediate emergency had passed, the doctor left and started home. Shortly after his departure, a second attack hit Bill so overpoweringly that he could not get his hand up to reach the bell to summon the nurse for help.

Bill had found this AA way of life and he knew the meaning and the power of prayer. He prayed as we alcoholics have been taught to pray: "If this be God's will, let me accept

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it. But if it *not* be God's will, let something be done about it." Bill accepted the fact that he, himself, was powerless.

As the tired doctor drove toward home, something suddenly told him to go back to the hospital. The compulsion was so strong that, without knowing why he did it, he turned his car around, drove back to the hospital and returned to Bill's room. As he entered, Bill was still groping futilely for the bell.

Bill is alive today. And that doctor is now a believer in a Power greater than himself.

When it was all over the two men compared notes. The doctor couldn't understand what had happened to him. Why had he turned his car around in the middle of the night to see this patient? The parapsychologist may answer: Extra-sensory perception, or telepathic communication. The physical scientist may explain it as coincidence.

Prior to AA, this was the way I thought. Now I believe with all my heart that a Power greater than ourselves entered into the lives of Bill and Dr. Jones that night; a Power that brought the doctor back to the hospital to administer drugs and oxygen which pulled Bill through that second attack.

This leads to a long avenue of thought. I agree with those who say that as alcoholics we are faced with mental and emotional problems. But let us also never forget the physical aspect of this problem. We are allergic to alcohol in any form. This simple physical fact, and the story of Bill and his doctor, is the essence of my message.

Have you told your family doctor that you are an alcoholic? If you have not, serious consequences could result. There are many concoctions on the drugstore shelves today that alcoholics like you and me simply cannot take with impunity.

An experience from my pre-AA days can give you a rough idea of what I mean. When a doctor friend went on a vacation he gave me one of the softest jobs I ever had. He wanted a qualified medical man in his office in case any of his patients got sick, an emergency arose, or a prescription needed refilling.

Since I was aware I had a drinking problem, I made up my mind that for the three weeks this job was to last, I was going to stay sober. I did all right that first week. I saw no more than two or three patients a day, and played gin rummy with the doctor's nurse the rest of the time.

In the middle of the second week I was troubled with a slight chill, an ache or two and a dry cough. As we sat playing cards, I innocently asked the nurse, "Have you got anything around here that's good for a cough? (This question, remember, from a doctor of medicine, and alcoholic—though not yet in AA.) She got a little bottle of aromatic cough medicine and set it down on the card table.

I polished off that cough medicine before the gin rummy game was over; and on the way home from the office that night, the old alcoholic compulsion hit me full force. I never got back to that soft job again. It all started from a few drinks of cough medicine containing alcohol.

That is why I suggest that, if you are an alcoholic, you owe it to yourself to sit down with your family doctor for fifteen or twenty minutes and tell him your AA story. Tell him about this allergy you have to alcohol in *any* and *all* forms. Ask him to include this information among your personal data in his files. If you don't tell your doctor these

things, then you, in my opinion, are not working the AA program because you are not fundamentally honest with yourself.

Sometimes the more cautious or timid newcomer to AA raises the question whether "going on record as an alcoholic" with a physician, in some way violates the Tradition of anonymity. First of all, the laws of the United States, from local to national level, recognize a communication between a doctor and his patient as privileged and inviolable, as is that between a supplicant and his priest, minister or rabbi. What you tell your doctor is your business and his. He is a member of a profession that was protecting the anonymity of its patients centuries before AA came into being. He will no more reveal the nature of your condition than he will gossip about the pastel hues of your liver.

You will find that your doctor is interested in your story. All over our country, doctors are showing increasing interest in this thing called alcoholism. As an M.D. I learned more about alcoholism by becoming a drunk than I learned from any formal lecture in a medical school or clinic. An old Texas friend, who also is a doctor in AA, has remarked, "People like you and me who are alcoholic are probably the only 'book' some of our colleagues will ever read."

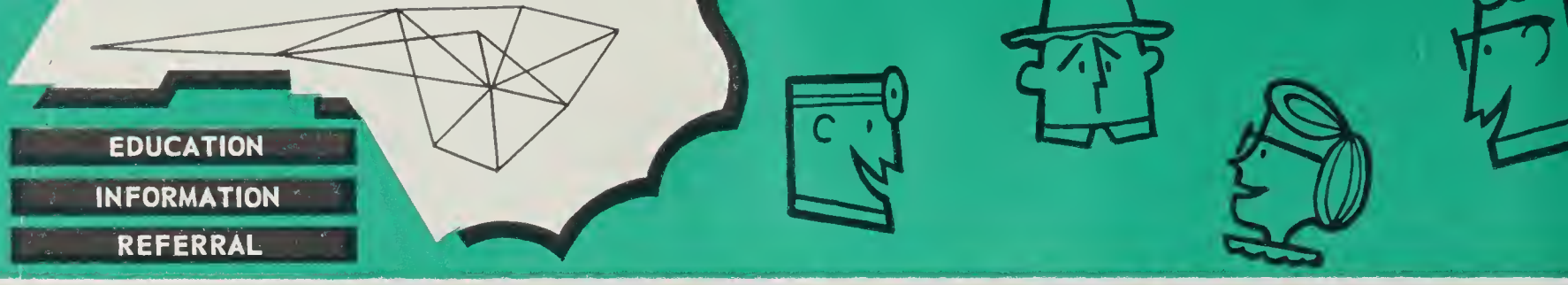
Your doctor probably has more work than he can do. He hasn't time to read all the literature that comes to him from medical publishing companies. But when *you* come in—a former hopeless stumbling drunk who is now sober—he is going to want to know how and why this thing happened. We can "Twelfth Step" our doctors.

In the United States the doctor-to-patient ratio varies from one doctor for 700 people to one for 5,000. If your doctor's practice is close to being typical, he will have 1,500 "potential" patients. Applying current figures, between three and six per cent of these will be alcoholics. Your doctor, then, has from forty-five to ninety men and women who do now, or who may very soon, present some of the symptoms you tell him about.

Perhaps he remembers, a year or two ago, how you would get drunk and call him at two or three in the morning. You didn't pay your bills, or you stormed into his office to berate him and cuss him out, and perhaps you concluded your tirade on his unfitness to practice medicine by throwing up on him. Yet, now you sit, clear-eyed, neat and sober. You even pay your bill promptly. All this *does* represent a change. You will pique his scientific curiosity.

And now, some morning when his phone rings and it's a drunk, or the hysterical wife of a drunk, you may be responsible for a change in the attitude of that doctor toward the sick alcoholic. It may be that now, at two in the morning, he will get up and go again, to call on one of these "incurables." Instead of just giving him a shot, or some paraldehyde, tranquilizer, or goof balls, it may be that he will say: "Ed, this is the sixth time in two months I've been out here to see you. You're an alcoholic. Why don't you call Alcoholics Anonymous? I had a patient just like you. I remember him well." And without breaking your anonymity, he can tell Ed about you, and what AA has done for you.

I agree with what Bill W. said in that wonderful article, "Let's Be Friendly with our Friends." I think the doctors are willing to be friendly with us if we'll be friendly with them. By letting the doctor in on it, too, we protect our own personal sobriety and gain a powerful ally in carrying the message to others.



Currently in North Carolina there are fourteen

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Sgt. Carrol R. Owens, Chairman
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary — Phone: 942-7253

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellermann, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
602 Snow Building
Mrs. Olga Davis, Executive Director — Phone: 682-5227

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
Rev. Edward Laffman, Director

LAURINBURG
Scotland County Citizens Committee on Alcoholism
308 State Bank Building—P. O. Box 1229
M. L. Walters, Executive Secretary — Phone 276-2209

NEW BERN—
Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
Gray Wheeler, Exec. Secretary
Phone: 637-5719

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
225 West Morehead Street, P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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